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Psychiatry in Chicago 1935–1957 As I Saw It

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I CAME to Chicago in 1935 to join the staff of the newly organized Division of Psychiatry in the Department of Medicine of the University of Chicago Clinics and to obtain training in psychoanalysis at the Institute for Psychoanalysis of Chicago. At that time the psychiatric situation seemed to me to be about as follows: The Institute for Psychoanalysis, which had been founded in 1932 by Dr. Franz Alexander was actively carrying on training activities and research in psychoanalysis. The Institute for Juvenile Research, under the directorship of Dr. Paul Schroeder, was busy in the field of child psychiatry in training and research, and in providing services at the outpatient level.

At Loyola University School of Medicine Dr. Francis Gerty was Chairman of a combined Department of Psychiatry and Neurology and found it difficult to get support for the essential teaching activities. As Superintendent of Cook County Psychopathic Hospital, he directed the residency training program in psychiatry there. At the University of Illinois College of Medicine, the Department of Psychiatry, under Dr. H. Douglas Singer recently had been separated from the neurological section, and was functioning at undergraduate and graduate levels and in research activities in and from the Psychiatric Institute at the Research and Educational Hospitals.

Rush Medical College, one of the two medical schools under the University of Chicago, provided for their students a few lectures by Dr. David Rotman and some clinical demonstrations at the Cook County Psychopathic Hospital. At Northwestern University Medical School, the Department of Nervous and Mental Diseases was under the chairmanship of Dr. Lewis J. Pollock, and Dr. Clarence Neymann gave lectures and demonstrations in psychiatry to the medical students. If I remember correctly, Michael Reese Hospital had a Mental Hygiene Clinic and carried on some residency training.

There was a Psychiatric Institute at the Municipal Court of Chicago, directed by Dr. David Rotman. The Criminal Court of Cook County had what was called a Behavior Clinic. At Elgin State Hospital, Dr. Charles F. Read was conducting an active program in research and training. The psychiatric in-patient unit at the

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From Presidential Address Read at the Annual Meeting of the Illinois Psychiatric Society, April 17, 1957.

University of Chicago Clinics and Billings Hospital was the first psychiatric unit in a private general hospital in the area. The chief psychiatric sanitaria were outside the city in the metropolitan area of Chicago, several of them in Wisconsin, in or near Milwaukee. The Chicago State Hospital at Dunning had suffered considerably from politics.

There was no psychiatric society in 1935. The Chicago Neurological Society, founded in 1898, had been the only professional society with which psychiatrists could affiliate themselves up until 1931. That year the Chicago Psychoanalytic Society had been organized and thus provided affiliation for psychiatrists specializing in psychoanalysis. Other psychiatrists, however, had to await organization of the Illinois Psychiatric Society, this society, in 1939.

The term neuropsychiatry was used by many in preference to the term psychiatry, thus indicating the ambivalence and insecurity felt by those in the field who had come to it through neurology and who had little or no formal training in psychiatry. They seemed to fear emphasis upon the psychological aspects of mental disorders. The new Division of Psychiatry, at the University of Chicago School of Medicine, was not a department but a division of the Department of Medicine. The inclusion of psychiatry as a required subject in the University of Chicago Medical School curriculum was a much delayed forward step which promised much for the future of psychiatry in the area since its psychiatric staff was on a full-time basis as were the staff members of the other clinical departments at the University of Chicago. The residency training programs in psychiatry in 1935 were not well organized for instruction of the residents in training and the number of those in training was few at any one hospital. In fact, the total number was not an impressive one.

The methods of treatment then available had just begun to include the general use of psychotherapy in a tentative way. Reliance still was placed upon hospitalization; hydrotherapy; sedation with bromides, barbiturates, and paraldehyde; occupational and work therapy and a little recreational therapy, the tentative use of some endocrine products; chemical and fever therapy for general paresis and syphilis of the central nervous system; just the beginnings of organized attempts at group therapy; emphasis upon persuasion, reassurance, and exhortation of patients as psychotherapeutic measures and some use of hypnosis. Shock treatments with insulin or metrazol, had not then come into use here in Chicago. The private practice of psychiatry was being carried on but did not seem to be important except in its hospital aspects, not as office practice.

I would like to return to my advent in Chicago. The newly organized Division of Psychiatry, at the University of Chicago Clinics, was headed by Dr. Roy Grinker, with the rank of Associate Professor of Psychiatry, and had as other members of its staff Dr. Margaret Gerard, as Associate Professor, Dr. Herbert Chamberlain, as Associate Professor assigned to Bobs Roberts Hospital in the Department of Pediatrics, and your speaker as an Instructor. Dr. Jules Masserman was Chief Resident. Drs. Helen Gilmore and Harry Nierenberg were assistant residents, each for six months. Dr. Grinker, who had been Associate Professor of Neurology, was stimulated to develop an interest in psychoanalysis and psychiatry by Dr. Franz Alexander during the latter's year as Visiting Professor of Psychoanalysis at the University of Chicago in 1930-31. This led him, with the support of the University of Chicago and the Rockefeller Foundation, to undertake a personal analysis with Sigmund Freud in Vienna, a study of the psychiatric clinics in western Europe, and of the set-up of psychiatric clinics, teaching hospitals, and medical schools in the United States with a view to establishing the Division.

His organization of the Division included a close working relationship with the Otho Sprague Memorial Institute, then directed by Dr. H. Gideon Wells, Professor of Pathology and Chairman of that Department. This active affiliation with the Sprague Institute and its members, which was intended to be a main source of support and stimulation, also was for collaboration in doing research in psychiatry. The staff of the Institute included physicists, biochemists, pathologists, clinical and experimental psychologists, immunologists, neurologists, and staff members of the Division of Psychiatry, the psychiatrists in the group. The 11-bed psychiatric in-patient unit, though small, proved itself at that time to be relatively satisfactory in

handling the problems of psychiatric in-patients, excluding only very disturbed patients and children. There was an active out-patient service which Dr. Grinker asked me to organize and direct. Nursing services, occupational therapy, clinical psychological services, and psychiatric social work were provided also. Psychiatric consultation services were afforded the other clinical departments.

The teaching of psychiatry to undergraduate medical students was a major function of the Division. Such activity then began in the third quarter of the sophomore year when members of the Division joined with members of other clinical divisions in teaching medical students something of how to approach patients clinically during physical examination and history taking. Some psychiatric lectures were given to the junior class, and junior medical students were given a two-week clerkship on the psychiatric in-patient service. Lectures also were given to the senior class in medicine, each member of which spent some time in the psychiatric out-patient department, for brief periods weekly over a term of six weeks. There was active affiliation, though unofficial, between members of the staff of the Division and the Institute for Psychoanalysis of Chicago.

In the spring of 1936 Dr. Grinker resigned as Director of the Division. He was succeeded by Dr. David Slight who came to Chicago in June of 1936 by way of McGill University, Montreal, the Maudsley Hospital in London, and the University of Edinburgh. Dr. Donald Morrison became the chief resident in the fall of 1936. Dr. Masserman became an instructor during that year. In 1937 Dr. Henry Brosin joined the staff as instructor. Among subsequent members of the resident staff, were included Doctors Joan Fleming, Kurt Eissler, Charlotte Babcock, and Jay McCormick.

Considerable research activity went on in the Division under the stimulus first of Dr. Grinker and then of the Sprague Institute and its members as well as under the individual initiative of the staff of the Division. The research was recognized as including promising and important endeavors and was referred to by Dr. John C. Whitehorn in his chapter on Research in Psychiatry in the Memorial Volume published by the American Psychiatric Association at its 100th Anniversary in 1944. Included among the members of the Sprague Institute were Professor Heinrich Kluver, an experimental psychologist, who had developed the method of equivalent and nonequivalent stimuli in the study of the behavior of monkeys; and Professor Ward Halstead, who developed the now well-known Halstead battery of tests for organic brain conditions.

I carried on work in collaboration with Dr. Allen T. Kenyon, endocrinologist for the Clinics, on eunuchoidism and the effects of testosterone propionate on impotence and studied a eunuchoid patient by the psychoanalytic method. Dr. Masserman and I collaborated on follow-up studies on both in-patients and out-patients. He began his experimental work with animals by stimulation of the hypothalamus in cats, using the Horsley-Clarke stereotaxic apparatus.

Dr. Margaret Gerard had taken over the direction of pediatric psychiatry shortly after Dr. Slight succeeded Dr. Grinker as director of the Division. When she left to join the staff of the Institute for Psychoanalysis, Dr. Adrian Vander Veer succeeded her. I remind you of the full-time plan followed at the University of Chicago Clinics in the clinical departments of the medical school since this is important to remember in making any comparisons with other medical schools in the city and the set-up of their psychiatric departments for undergraduate teaching, research, and residency training.

There were many important developments in psychiatry in the Chicago area beginning shortly after 1935 and early 1936. Those that played major parts in changing the psychiatric scene and contributing to progress in the field at all levels (encompassing undergraduate teaching, residency training, research, private practice, psychotherapy, psychoanalytic training, psychiatric units in general hospitals) I should now like to comment upon.

If I were asked which one person has done the most to facilitate and stimulate psychiatric progress in Chicago in the last 25 years, I would say that it was Dr. Franz Alexander. The major credit for the stimulation, organization, and development of psychoanalysis in Chicago belongs to him. True, Dr. Lionel Blitzsten had been practicing psychoanalysis in Chicago before

Dr. Alexander's arrival in 1930 as Visiting Professor of Psychoanalysis at the University of Chicago. Dr. Alexander met with no little opposition and criticism during his first year in the city. You may recall having heard that he spent the following year, 1931-32, at the Judge Baker Foundation in Boston working in collaboration with Dr. William Healy, the latter himself an innovator of what later became child guidance clinics in this country, and led to the establishment of the Institute for Juvenile Research here in Chicago.

The first staff of the Institute for Psychoanalysis, under Dr. Alexander, included Dr. Karen Horney as Associate Director, Doctors Thomas French, Helen McLean, and Catherine Bacon, with Dr. Lionel Blitzten and Karl Menninger as Lecturers. The Institute was supported by a number of businessmen in the city and by foundations; support had been obtained from both groups to a large degree by Dr. Alexander. Some of the early students at the Institute for Psychoanalysis were from Chicago but the majority came from out of town, many of them commuting on week-ends. Others came to work in the city while they obtained their psychoanalytic training.

The active though unofficial affiliation through students, with the University of Chicago Clinics; Michael Reese Hospital; the Institute for Juvenile Research; Elgin State Hospital; the University of Cincinnati; the Menninger Clinic, at Topeka, Kansas; and Wayne University College of Medicine, Detroit, influenced psychiatric development in these places. In 1936, funds had been obtained from the Rockefeller Foundation for the establishment of fellowships in psychoanalysis, to be given preferably to persons who intended to follow an academic career of teaching and research. These fellowships facilitated the training of several candidates and provided help for others for several more years before the Rockefeller Foundation withdrew its support of this plan.

Dr. Alexander and his staff carried on active research by the application of the psychoanalytic method in the area of what later became known as psychosomatic medicine. Dr. Alexander's book, *The Medical Value of Psychoanalysis,* was published in 1936. Since then, many papers and monographs have been published by the staff of the Institute for Psychoanalysis. Dr. Alexander was interested in affiliating the Institute actively with one of the medical schools in the city. He first hoped to do this with the University of Chicago. However, he was given an appointment at the University of Illinois College of Medicine in the Department of Psychiatry under Dr. Singer where for some years he gave his course of Introductory Lectures to Psychoanalysis.

As I said earlier, I came to Chicago to obtain psychoanalytic training. I had hoped to begin my personal psychoanalysis immediately with Dr. Alexander. This story is a familiar one, for many people came to Chicago before and after 1935 with identical hopes. I had to await the arrival of another training analyst, Dr. Therese Benedek, in May of 1936. The available training analysts up to that time had been Doctors Alexander, French, and Blitzsten.

The Rockefeller Fellowship provided funds to supplement whatever the individual candidate could afford to pay for his personal psychoanalysis and towards the fees which the Institute charged for didactic courses and supervision of control cases. The figure set as normal for a training analysis then was $5 a session. Each fellow paid whatever he could afford and the rest was made up from the fellowship fund. The five fellows appointed in 1936 included Doctors Milton Miller, Jules Masserman, Martha McDonald, Eugene Falstein, and your speaker.

In those early days, the Institute required each candidate to take an oral examination and the Chicago Psychoanalytic Society required the presentation of a thesis as a qualification for associate membership. The latter requirement was abolished with the separation of the Institute and the Society in 1947 when, I believe, Dr. Frances Hannett was the last person to read a thesis for admission to the Society.

Early in the 1940's Dr. Alexander became interested in the application of the psychoanalytic technique in the treatment of patients in which psychoanalysis as such was not indicated or feasible. The short-lived Brief Psychotherapy Council was set up and held at least three meetings up to 1946. The word *brief* occasioned considerable discussion, even acrimony, and did seem to be poorly chosen as an adjective

to designate the difference between psychoanalysis and psychoanalytic psychotherapy.

During the early 1940's Dr. Alexander had begun a seminar at the University of Illinois Neuropsychiatric Institute at which the psychosomatic approach to medical cases other than purely psychiatric was demonstrated by him and discussed. For several years I helped him carry on this seminar which attracted much interest and stimulated many persons in other fields of medicine, particularly internal medicine, to take an active part in investigating the influence of psychological and emotional factors in many illnesses.

Mention should be made of the work of some of the other members of the staff of the Institute. Dr. Thomas French, in his two volumes on the *Integration of Behavior* in which he sets forth his basic postulates and discusses the integrative process in dreams; and also the work of Dr. Therese Benedek on the *Psychosexual Functions in Women,* a field closely allied to my own interests in the relation between the endocrines and mental disorders, especially the psychosexual functions in men.

The tremendous influx of candidates for psychiatric residency training and psychoanalytic training following World War II created a difficult situation since training facilities in Chicago could not begin to handle all the suitable applicants. This eventually led to active collaboration between the Institute and the psychiatric training facilities at the University of Chicago Clinics, the Illinois Neuropsychiatric Institute, and Michael Reese Hospital, eventuating in the formation of the Associated Psychiatric Faculties of Chicago, about which more anon.

Let us turn back now to some of the developments elsewhere in the city following 1935-36. When Dr. Grinker resigned from the University of Chicago Clinics, he went to Michael Reese Hospital where he became the director of the Division of Neuropsychiatry. This was a new development at Michael Reese. He was joined by Dr. Jacob Kasanin as the head of Psychiatry. After Dr. Kasanin left for San Francisco to take over the direction of psychiatry at Mount Zion Hospital, Dr. Maxwell Gitelson, who had been chief of staff at the Institute for Juvenile Research, joined Dr. Grinker. Eventually a psychiatric in-patient unit was opened at Meyer House, research activities instituted, and residency training stepped up. During Dr. Grinker's absence in World War II with the Army Air Forces, Dr. Gitelson was acting director of the division, with Dr. Emmy Sylvester in charge of child psychiatry.

Dr. Henry Brosin, of the University of Chicago Clinics, had been a reserve officer and was called to active duty in January of 1941. I, who had continued on the staff there as Assistant Professor of Psychiatry, resigned in 1943 to enter into half-time private practice and to join the staff of the Department of Psychiatry, University of Illinois College of Medicine, on half-time under Dr. Gerty, with the rank of Associate Professor of Psychiatry and as Associate Director of the Psychiatric Division of the Illinois Neuropsychiatric Institute. Dr. Gerty had succeeded Dr. H. Douglas Singer as Professor of Psychiatry and Head of the Department there, in July of 1941. He was succeeded as Professor and head of the Department of Psychiatry and Neurology at Loyola by Dr. John Madden and as Superintendent of Cook County Psychopathic Hospital by Dr. Vladimir Urse. On December 1, 1941, the Illinois Neuropsychiatric Institute had been opened, just six days before Pearl Harbor. Dr. Gerty directed the Psychiatric Division and Dr. Eric Oldberg the Neurological and Neurosurgical Division.

The Neuropsychiatric Institute had been a brain child of Mr. Willoughby C. Walling, President of the Board of Public Welfare Commissioners, (which was an advisory body to the State Department of Public Welfare of Illinois) and of Dr. Singer. It had been first thought of as a psychiatric institute, but Dr. Singer and Mr. A. A. Bowen, then Director of the Department of Public Welfare, deemed it advisable to make it a neuropsychiatric one. The fiscal administration of the Institute was under the direction of the Department of Public Welfare with Dr. Harry Hoffman, then the State Alienist, serving as Executive Officer. Much time and thought were devoted to the planning of the Institute, especially of the neurological division which was set up just as Dr. Oldberg and his associates wished it. This also was true of the basement laboratories of the Institute (which were included in the Psychiatric Division).

These had also been planned carefully in detail primarily by Dr. Ralph Gerard then of the University of Chicago's Department of Physiology. The physical setup of the psychiatric division was apparently not as well planned or at least supervised closely by Dr. Singer, for when Dr. Gerty and his staff took over, they found many things about which to be critical. The direction of all treatment, research, and teaching in the Institute was under the University of Illinois College of Medicine Departments of Psychiatry and Neurology respectively. All the functions of the Institute and its administration were transferred to the University of Illinois in 1951, except that the State Psychopathic Institute, under the direction of Dr. Percival Bailey, continued to maintain its offices in the building.

Although World War II was upon us when Dr. Gerty took over the direction of the Psychiatric Division of the Institute and of the Department of Psychiatry, he got such good support from the then Executive Dean of the Chicago Professional Colleges of the University of Illinois, Dr. Raymond B. Allen, who was also Dean of the College of Medicine, he was able to make progress immediately in developing teaching and research in psychiatry. Up to then, the budget of the Department of Psychiatry, apart from the support it received from various foundations and grants, and from the Department of Public Welfare, had totalled about $16,000 a year. Under Dr. Gerty and with Dr. Allen's active assistance, the Department of Psychiatry acquired an increased budget slowly and gradually over the years, reaching an amount at least 10 times greater.

Teaching of psychiatry to undergraduates through all four years of the medical school course was instituted and an active research program developed in the basement laboratories under Dr. Warren McCulloch, neurophysiologist, and his associates, Dr. Ladislas von Meduna, Dr. Raymond Klein, biochemist, and later Dr. and Mrs. Frederick Gibbs in electroencephalography. Dr. Gerty began a new regime regarding admissions to the Psychiatric Division of the Institute, where the facilities for in-patients amounted to 35 beds for adults and 10 for children. Instead of being at the beck and call of or under the influence of outside sources of a political sort and of a group of ex-patients banded together in an association, he instituted the policy of accepting patients who fitted in with the on-going teaching and research activities in the Division. This proved successful and has continued to be so over the years. From Dr. Singer's former staff, Dr. Gerty had as active assistants Doctors Beulah Bosselman, Irene Sherman, Alfred Solomon; and as his Assistant Director, Dr. I. Ronald Sonenthal. Dr. Stanislaus Szurek was in charge of the in-patient ward for children. He and other members of the staff of the Institute for Juvenile Research assisted in the teaching of undergraduates.

When I joined the staff in September, 1943, the exigencies of war times made it difficult to get adequate help, let alone find suitable candidates for the residency training program. In fact, one had to accept almost anyone who applied as well as to use whatever other sources of help were available among the resarch assistants, fellows, and junior staff members. Despite these difficulties, many improvements were made in the residency training program, the in-patient service, the out-patient clinic, and the consultation service. In addition, regular staff meetings were instituted, and seminars for the review of psychiatric literature, and later for psychotherapy and psychosomatic demonstrations were begun.

After the end of World War II, the residents increased in number from three to nine and many persons from elsewhere came to us for part of their residency training. The residency training program became an excellent one at this period: most of the residents also sought psychoanalytic training and many began such training before they completed the residency. Several later joined the junior staff and were helpful in carrying on the residency training program and teaching of undergraduates which had remained a major function of the Department. Dr. McCulloch and his co-workers, as well as Dr. Meduna and the Gibbses, were productive in writing papers setting forth their researches. Such productivity continued later under Dr. Ralph Gerard, who succeeded Dr. McCulloch, and most recently under Professor Leo Abood, Dr. Gerard's successor. Professor David Shakow joined the staff as Professor of Psychology and Director of the Psychological Division of the Department. He developed that division and took a pre-eminent place in the

training of clinical psychologists in the psychiatric field. He left two years ago to join the staff of the National Institute of Mental Health at Bethesda, Maryland.

There were few full time staff members in the Department of Psychiatry (at the University of Illinois) except for those who devoted full time to research such as Dr. McCulloch, Dr. Meduna, Dr. and Mrs. Gibbs, Professor Klein, and later Professor Shakow. There were some minor full time clinical positions, at the level of Research Assistant. Otherwise, only the resident staff were on a full time basis. A number of the staff were on part time. Dr. Gerty was on half-time, as was I, as his Associate Director. While this seemed to work out well for a few individuals, largely part time workers seemed to us to be more committed and involved in their activities outside the medical school, such as private practices, than in their medical school functions. It was clearly not sufficient to have only the equivalent of one full time person setting policy and administering teaching, research, and service programs. Dr. Gerty was eclectic in his choice of staff for the most part as witness the inclusion of Dr. Alexander and the author on it, but had preferred to fill up the positions and push the work on the physiological side before doing so on the psychological side. The clinical staff was weak in that there was no full time person of broad experience to direct the clinical activities. This was due, mainly to the relatively low salaries available so that many persons felt they had to supplement their income by part time private practice.

In 1952 I resigned my administrative paid position at the University of Illinois College of Medicine, to devote at least a quarter of my time to efforts at research in psychotherapy. Since then I have collaborated with David Shakow, Rae Shifrin Sternberg, Ernest Haggard, and other psychologists and with Doctors Leon Bernstein, Morris Sklansky and Joel Handler in making preliminary studies of sound-film recording of psychoanalytic therapy. Currently, considerable change in personnel is occurring in the Neuropsychiatric Institute. Drs. Franz Alexander and George Mohr have retired from the staff to go to California. Dr. Marc Hollender resigned to become Professor of Psychiatry and Chairman of the Department of Psychiatry at the State University of New York Medical Center at Syracuse.

Let me return now to the topic of the Associated Psychiatric Faculties of Chicago. Before World War II, Dr. Grinker in his presidential address to the Chicago Neurological Society had proposed a plan for co-ordination of psychiatric and neurologic training in the Chicago area. This was a basis for later development of the Associated Psychiatric Faculties of Chicago. The greatly increased demand for residency training at all the psychiatric hospitals in this area beginning in 1946-47 led to collaborative efforts in this field by co-operation of the University of Illinois, the University of Chicago, Michael Reese Hospital, and the Institute for Psychoanalysis. Doctors Brosin, Grinker, and I were active with the support of Dr. Alexander, Miss Helen Ross, Dr. Mohr, and Dr. Gerty in planning this organization which was incorporated in 1948. Its goal was to attempt to co-ordinate and supervise as well as to maintain standards of excellency in psychiatric residency training in Chicago, to facilitate training in psychoanalysis, and to aid in the selection of candidates of the highest caliber for training.

For a few years this was a successful venture. You may read about it in Dr. Brosin's article, in the American Journal of Psychiatry in 1952. Under its aegis, group selection of residents was made over a period of four or five years for three residency training programs in the city and at first also for candidates for the Institute for Psychoanalysis. The latter was dropped later on. Selections were made also for rotating psychiatric residencies, support for which was obtained from grants from the United States Public Health Service. Unfortunately, the successful collaboration did not continue. It was interrupted at first by Dr. Brosin's departure to the University of Pittsburgh and by the unsettled state of affairs in psychiatry at the University of Chicago Clinics, and then through lukewarm support, perhaps more correctly called an ambivalent attitude on the part of some of the members. At present, the Associated Psychiatric Faculties of Chicago—although it has been broadened to include Chicago State Hospital and Northwestern University psychiatric training programs—is not performing as efficiently and effectively as heretofore. This I regret.

Upon his return from service with the Army Air Forces, Dr. Grinker became active in setting

up a much enlarged residency training program in psychiatry at Michael Reese and in getting sufficient endowment to start construction of the Institute for Psychiatric and Psychosomatic Research and Training there. Besides this, he encouraged and stimulated considerable research. Under his guidance, a group has attempted to set up a unified theory of human behavior. He and his co-workers have carried on important work in the field of psychosomatic medicine and in his monograph on *Psychosomatic Research* he reviews critically the various theories in that field. He and his colleagues are carrying out investigations into anxiety from biochemical and psychological viewpoints. Dr. Grinker has been president of all three of the societies in his specialties in the city—namely, the Chicago Neurological Society, the Chicago Psychoanalytic Society, and the Illinois Psychiatric Society (as I have).

On Dr. Brosin's return from World War II army service, he reorganized the Division of Psychiatry at the University of Chicago, greatly enlarged its training program for residents, and was given continued help through the Rockefeller Foundation (which had initiated and supported the original program there), and also from training grants from the United States Public Health Service. He was handicapped, however, as was his successor Dr. Nathaniel Apter, by the administrative set-up at the University of Chicago and the apparent failure of the University to directly and wholeheartedly support psychiatry financially and in spirit. For the past year and a half, there has been a Department of Psychiatry there with Dr. C. Knight Aldrich as Chairman. This provides opportunity to make the progress which heretofore had been stymied in a number of ways and directions.

While there has been greater acceptance of the desirability of better teaching of psychiatry and the psychosomatic approach to medical students, there still exists an attitude of resistance to good implementation of the idea. Psychiatry does not have the official status it is accorded by the Army, Navy, and Air Force, and by the Veterans Administration and the U.S. Public Health Service. In these instances it is recognized as a major division along with general surgery and general medicine. At most medical colleges it is not included among the major divisions: surgery, medicine, obstetrics and gynecology, and pediatrics. I am not making a plea that it should be so included but merely stating the facts. Many of the senior staff of other departments in medical schools seemingly support the importance of psychiatry and its place in the medical curriculum. Some appear to mean by this that they recognize the importance of environmental influences in health and illness and are willing therefore to include sociological and economic factors. They seem to shy away from acceptance of psychological factors (including personality make-up and emotional attitudes) as significant influences in the production and treatment of illness, although they give lip service to and profess intellectual appreciation of this viewpoint.

Need I say very much at this point other than to assert what most of you know—namely, that over-all progress has been made in Chicago in the development of psychiatric teaching and training and research since 1935. This includes much greater activity in the Veterans Administration Hospitals; a new lease on life at the Chicago State Hospital, under Dr. Kalman Gyarfas; continuation and extension of Dr. Gerty's former program in the Department of Psychiatry and Neurology at the Stritch School of Medicine of Loyola University under Dr. John Madden as Professor and Chairman of the department; direction of the activities of Cook County Psychopathic Hospital under Dr. Gerty's successor there, Dr. Vladimir Urse; the initiation and development of a Department of Psychiatry at the Chicago Medical School under Dr. Harry H. Garner as Professor and Chairman of the Department; the reorganization of psychiatric training at Northwestern University under Dr. Benjamin Boshes, Chairman of the Department of Nervous and Mental Diseases; continued vigor in the Institute for Psychoanalysis under its new director, Dr. Gerhart Piers; and the plans for the new State Psychiatric Institute in the West Side Medical Center area under the direction of Dr. Percival Bailey. The newly constituted Psychiatric Research and Training Authority of the State of Illinois which began its operations July 1st, 1957 and functions as an independent Board to receive and dispense funds for psychiatric research and training in the state; its funds are to be derived from payments made by persons who are not indigent and who receive treat-

ment in the state mental hospitals. The number of psychiatric units in general hospitals has increased manifold. Besides, the University of Chicago Clinics, Michael Reese Hospital, and St. Luke's Hospital—Presbyterian Hospital have had units, as have Chicago Wesley Memorial, Mercy, Loretto, St. Joseph's, Passavant, Mount Sinai, and Evanston Hospitals.

In view of the occasion, it seems appropriate that in some of my remarks tonight, I should touch briefly upon the history of this society. To do so is pertinent in view of the title of this address. Only the older members of the Society are fully aware of its relatively short life. Its conception occurred in the fall of 1938 when a small group of Chicago psychiatrists, among whom some of the most active included Drs. Kasanin, Singer, Conrad Sommer then Medical Director of the Illinois Society for Mental Hygiene, Gerty, Slight, Neymann then Chief of Staff at Cook County Psychopathic Hospital and Associate Professor of Psychiatry at Northwestern University School of Medicine, and Dr. Ralph C. Hamill, Associate Professor of Psychiatry, Rush Medical College. At the invitation of this group, a larger group of psychiatrists was assembled to hear the proposal for setting up a psychiatric society, and to draw up a constitution and by-laws. The group responded favorably and adopted a tentative constitution and by-laws. Dr. Singer became its first President and Dr. Sommer, its first Secretary-Treasurer.

There have been ups and downs in the quality of the meetings and of the scientific programs of the Society in the past 18 years. At times the quality has been very high. There were occasions when it looked as if the Society would die and be unlamented, for so few members attended meetings during some years that it was virtually impossible on occasion to conduct the business of the Society, let alone have a respectably-sized audience to listen to the speakers. I am happy that this year there has been such an active interest and good attendance at meetings. From my vantage point on the platform I have been able to count the attendance. With the exception of the one meeting when I was away last month, I know that well over 100 were in the audience to listen to the scientific program each time. Not all were members of the Society, but there was always a quorum to enable us to do business. Another problem of the Society throughout the years has been its tendency to represent mainly psychiatrists in the metropolitan area of Chicago and to leave members of the Society and other psychiatrists who lived elsewhere in the state without much opportunity for active participation. Something should be done about this. I hope it will in 1957, when I trust we will become officially a district branch* of the American Psychiatric Association by the action of its District Assembly, its Council, and its membership at its annual meeting.

You will have noted that I have not talked much about shock therapy, prefrontal lobotomy, insulin treatment, group therapy, and the tranquilizing drugs. This is not because I believe them to be of no help in treatment. I have used each of these methods in trying to help patients over the past several years and would still use them if I found them indicated for any individual patient's particular welfare. There has been a trend, however, not only here but in the country at large, to abandon psychological methods of treatment, understanding of mental disorders, and shock treatments and to substitute the new tranquilizing drugs. Recent research in the biochemical aspects of psychiatric disorders have led enthusiasts to declare that a revolution is upon us in psychiatry. I doubt that either it or the advent of the tranquilizing drugs will completely revolutionize our understanding and treatment of mental disorders any more than lobotomy, shock treatment, and insulin therapy did, as was pointed out by Dr. Percival Bailey in his Academic Lecture to the American Psychiatric Association here in May of 1956.

However, I do not agree with Dr. Bailey that Freudian psychoanalysis should be discarded, as he seemed to imply in his remarks. I continue to see its possible usefulness just as I see possible usefulness in other methods—physiologic, biochemical, or pharmacological. I see it as having usefulness as a theory and method for investigating and treating mental disorders just as I see biochemical studies, pharmacological investigations, and physiological inquiries as leading to results which may prove helpful in our understanding and treatment of patients. Since Dr. Bailey's address, I have heard many angry com-

*This was accomplished in May 1957.

ments about it. I, for one, would defend his right to his opinions and his expression of them, whether I agree with him or not.

And now I bring my remarks to a close with a quotation from Montaigne:

"But it is not only the heavens which science has equipped with ropes, engines, and wheels. It has forged for this poor little human body no less an array of retrogradations, trepidations, accessions, recessions, and aberrations. To fit the movements they see in man, into how many parts, orders, and stories have they divided the structure of the mind? They make of it an imaginary thing. They paw, rip, place, displace, piece, and stuff it to their hearts' content, yet to this day they have not grasped it. Not only in reality, but even in theory, they cannot master it so that some sound or cadence does not elude their architecture, enormous as it is and plastered with a thousand false and fantastic patches."

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Government research

At present the Department of Health, Education, and Welfare, and particularly its component health agency, the Public Health Service, occupies a dominant place in the support of medical research through the use of federal tax funds. In turn, the National Institutes of Health, the principal research arm of the Public Health Service, is charged with dual medical research responsibilities. One of these responsibilities is to conduct medical and related research within its own laboratories and facilities, including the Clinical Center at Bethesda, Maryland, and a number of field stations in various parts of the country. The other is to aid in the support of individual scientists or groups of scientists working in universities, hospitals, laboratories, and other public and private nonprofit institutions throughout the country. It may be of interest to note that more than two-thirds of National Institute of Health (NIH) funds are expended in our so-called extramural activities—grants and awards to non-federal scientists. Less than one-third is spent on intramural or direct operations. Although the NIH constitutes the primary focus of medical research activity within the Public Health Service, the other principal Bureaus of the Service—the Bureau of Medical Services and the Bureau of State Services—also are engaged in investigative and research activities. It is a fundamental belief of those who guide Public Health Service programs that an active research program is essential to the establishment and maintenance of highest standards of performance in all its assigned tasks. *Thomas D. Dublin, M.D. Medical Research. California Med. Mar.* 1958.

Preparing for Disaster

Burton C. Kilbourne, M.D., Willis G. Diffenbaugh, M.D.*, James G. Schroeder,† Chicago

THERE have been numerous civilian disasters which have stressed the value of preparedness on the part of those professions, institutions, and governmental agencies to whom the care of the injured is entrusted. Perhaps more impressive has been the adverse publicity resulting from lack of preparation. The threat of atomic warfare has created an awareness of the need for planning for the care of mass casualties. In other quarters there has been an attitude of resignation with a feeling that under such circumstances the disruption of facilities would be so widespread that no plans would be effective. Be this as it may, it has seemed to us at St. Luke's Hospital that we could develop a plan for civilian disasters, and in so doing stimulate the thinking of our staff along these lines to a degree which would result in greater ingenuity and more effective handling of mass casualties under any circumstances. Our work has been intensified since the Joint Commission On Accreditation of Hospitals has required that institutions have an approved disaster plan. We would like to relate briefly how our plans at St. Luke's Hospital have developed.

A committee composed of representatives of the medical staff, nursing, and administration was formed to study the problems. We reviewed our own outdated plan. We studied the reports of the Waco[1], Flint[2], Vicksburg[3], and Worcester[4] tornadoes, in which there were totals of 3,100 injured and 358 killed. Other material was obtained from the reports of the Coconut Grove[5,6] and Baltimore-Arundel fires[7,8] and the train wreck at Lynn[9].* Some of our committee could draw upon experiences of World War II and the Korean War. Participation in the care of casualties from the LaSalle Hotel Fire and local railroad wrecks add to the background.

From this study, we pictured a variety of casualties in unpredicted numbers arriving at the hospital by various conveyances. It could be necessary to send to the disaster scene, a mobile first aid team of hospital personnel. Our physical facility could be completely intact, disrupted to a variable degree, or without power and water. The hospital could be completely staffed or understaffed for the emergency, depending on the time of day or night. Those off duty might have difficulty in reaching the hospital.

Two alternative plans were proposed. Plan A (Figure 1) assumes an intact electrical and water system without impairment of our operating ability. Plan B (Figure 2) is designed for functioning in a limited capacity in the absence of power. The appropriate plan is to be declared in effect on receiving notification of a disaster. Switchboard operators are to call immediately all available personnel.

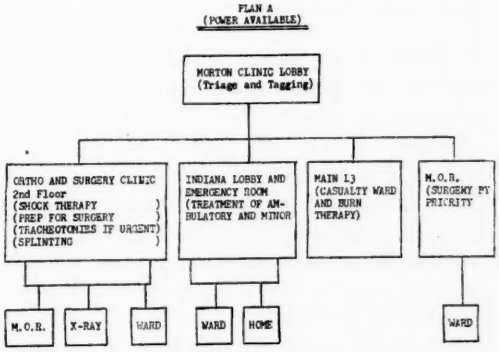

Figure 1

The flow of casualties is to proceed to one entrance where they will be met by a triage team. Here every effort will be made to avoid a bottle-

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†Assistant Administrator, St. Luke's Hospital.

*Collected reports of these and other disasters are now available in the booklet, "Readings in Disaster Planning" published by American Hospital Association.

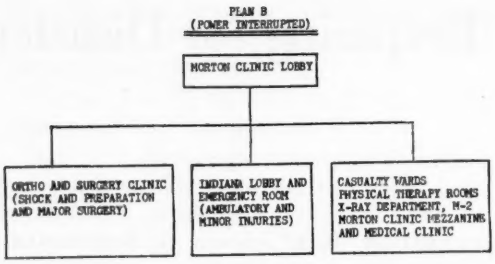
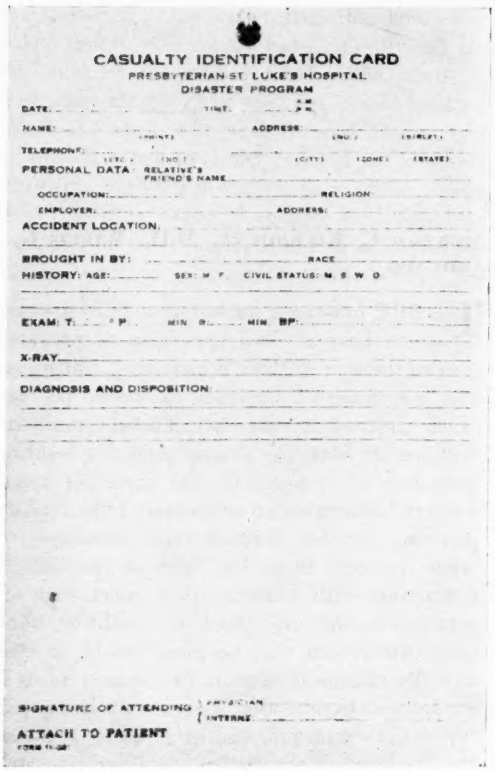

PLAN B
(POWER INTERRUPTED)
MORTON CLINIC LOBBY
ORTHO AND SURGERY CLINIC (SHOCK AND PREPARATION AND MAJOR SURGERY)
INDIANA LOBBY AND EMERGENCY ROOM (AMBULATORY AND MINOR INJURIES)
CASUALTY WARDS PHYSICAL THERAPY ROOMS X-RAY DEPARTMENT, M-2 MORTON CLINIC MEZZANINE AND MEDICAL CLINIC

Figure 2


CASUALTY IDENTIFICATION CARD

PRESBYTERIAN-ST. LUKE'S HOSPITAL

DISASTER PROGRAM

DATE: TIME:

NAME: ADDRESS:

TELEPHONE:

PERSONAL DATA: RELATIVE'S FRIEND'S NAME:

OCCUPATION: RELIGION:

EMPLOYER: ADDRESS:

ACCIDENT LOCATION:

BROUGHT IN BY: RACE:

HISTORY: AGE: SEX: M F CIVIL STATUS: M S W D

EXAM: T: P: MIN. R: MIN. BP:

X-RAY:

DIAGNOSIS AND DISPOSITION:

SIGNATURE OF ATTENDING PHYSICIAN / INTERNE

ATTACH TO PATIENT

Figure 3

neck, by limiting the function, as much as possible, to sorting, and directing to appropriate stations. Other teams are organized for shock and resuscitation, fractures, burns, major surgery, ambulatory treatment, anesthesia, medical problems, and consulting in the specialties. Members of the appropriate department of the medical and nursing staffs are assigned accordingly. The departments of radiology, pathology, pharmacy, surgical supply, and social service are similarly organized. The administrative services under the direction of the administrative representative include public relations, dietary, personnel, purchasing, admissions, housekeeping, maintenance, switchboard, and chaplain.

Each team, department, and service has reviewed its function under disaster conditions. Work areas or centers for triage, shock, and resuscitation, and care of ambulatory patients are designated to promote a smooth flow of casualties with the least possible congestion of transportation. A casualty ward can be prepared by conversion of a nurses' practice ward, and by placing cots in halls or the conference room. Other beds can be made available by selectively discharging or evacuating patients to hotels.

Each team has studied its requirements for personnel, space, and equipment. We believe it essential that each team member be sufficiently well acquainted with the plan to be able to direct inexperienced help enlisted on the spot.

The triage team in our plan is headed by surgeons who have had war experience. Appropriate alternates, house and nursing staff, clerks, and litter bearers complete the team. Their function is to examine sufficiently to determine the severity of injuries, and assign a priority. Priority 1 indicates that immediate treatment is necessary to save life. Priority 2 includes those needing early but not necessarily immediate treatment. In priority 3, life will not be endangered by waiting. In priority 4, the patient is moribund and beyond help. This team will render only the most vital life saving treatment at their station. An identification tag (Figure 3), upon which is recorded the diagnosis, medications, priority, and disposition will be attached to each patient.

Patients in shock or needing resuscitation will be taken to the appropriate station. Additional examination, transfusions, oxygen therapy, tracheotomies, splinting, and preparation for surgery will be carried out as needed.

The fracture and burn teams will standardize their treatment as far as possible. Their work will be carried on in the wards, the cast room, and operating room. In the ward, a responsible nurse or physician will keep a current list of patients awaiting operation, and in consultation with the surgeon in charge of the operating room, forward these patients to surgery as rooms are available. It will be desirable to segregate patients according to diagnosis, to concentrate

geographically as far as possible the work of the respective teams.

In the operating room, effort will be made to limit the extent of procedures without compromise of principle. Many wounds will be cleaned, excised, and dressed openly, with deliberate planning for secondary closure or revision. (This routine has been shown to be safest under these conditions.) Packs will be standardized for extremity, abdominal, chest, and head cases.

Ambulatory patients will be treated in the emergency room which will be reserved for this purpose. Adjacent recovery facilities are desirable. It can be assumed that 60 out of each 100 casualties will be in this category.

The work of the professional personnel will be directed and correlated by the chief of staff, committee co-chairman, and the nursing director and her deputies.

The administrative services have individually studied their functions. Public relations will handle press releases; nonessential and other personnel will be assigned to more urgent duties. Dietitians have taken stock of supplies which can be used with and without facilities for cooking. The maintenance department recognizes the importance of its function, especially if there is power or water disruption.

The director and assistant director will not only have the responsibility of co-ordinating these services, but must also handle liaison between the governmental agencies and the Red Cross.

This brief description is intended to give the highlights of the plan. It should be understood that it represents the combined effort of the committee and team members who were asked to contribute to the various sections of the plan. We believe that team members should be acquainted with the functions of the other teams, and to this end numerous meetings were held to approve and criticise each new section. The plan was presented to the staff at a regular clinical-pathological conference. It is presented in book form to each new intern class. Drill sessions are held twice a year in which 100 to 200 casualties from a simulated disaster are processed. Much interest is created when live casualties (volunteer student nurses) are tagged with horrifying diagnoses, and sumbit to "treatment." There are no shortage of litter bearers on these occasions. Each team designates its treatment, tabulates the number of casualties handled, and estimates time and supplies required. After an hour of this activity, a critique is held. Considerable interest is exhibited. It is amazing how fast our surgeons operate (on paper). We believe these rehearsals both disseminate and sustain the interest of the staff, and are particularly valuable as a means of familiarizing new personnel with the working details of the plan.

In conclusion, we recognize that no plan for a disaster can be perfect because of the large number of unknown and unpredictable elements. We believe that plans and rehearsals developed with broad participation of the hospital personnel, will lead to more nearly adequate equipment and supplies, and stimulate the individual ingenuity so necessary should an emergency arise.

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The Effects of Low Level Radiation Exposure

Austin M. Brues, M.D., Director of the Division of Biologic and Medical Research at the Argonne National Laroratories

Dr. Robert Adolph: The biologic effects of low level radiation exposure in man is a problem of real importance to the physician. As a humanist, he is concerned with the possibility of mutatogenic effects. As a clinician, he wants to know more about disease states attributable to radiation. Is the diagnostic and therapeutic use of X-ray—which heralded a new era of medical achievement—now to be looked upon as a necessary evil? What can we consider safe levels of radiation exposure? Is there such a thing as a safe level? These questions are currently hotly debated in lay publications. In the interests of less heat and more light we have asked Dr. Austin M. Brues, Director of the Division of Biologic and Medical Research at the Argonne National Laboratories, to speak to us today.

Dr. Austin M. Brues: It is true, we read a great many conflicting opinions in newspapers concerning the possible biologic effects of different sources of radiation and even among scientists, there is no general agreement. I would like to discuss the available facts and, to the extent that it is possible, reach objective conclusions.

To better understand the effects of low level exposure, it is necessary to give a brief discussion of acute radiation effects. It has been estimated that one exposure of about 500 r (roentgens) to the whole body is a lethal dose to 50 per cent of humans (so-called L.D. 50). Dogs are slightly more sensitive while the L.D. 50 for rats is higher, and for rabbits is about 800-900 r. Acute radiation exposure affects mainly the blood forming tissues. In mice, the effects take 10 days to three weeks to become evident, while in man, aplastic anemia may not develop until two months or longer after acute exposure. Dogs, rats, and rabbits may die within the first week because of acute destruction of the gastrointestinal epithelium and failure of these cells to regenerate.

Locally, concentrations of 2,000 r or more may be delivered by radioisotopes or X-ray therapy, and tolerated. When exposure is localized, the usual late response also is local and may become manifest as carcinoma of the skin or an osteogenic sarcoma. Where delivered by radium an exposure of a few hundred roentgens or more may produce bone changes 20 or 30 years later.

In discussing low level radiation exposure we speak in terms of mr (milli-roentgens): 100,000 mr is equal to 100 r.

It is known but perhaps not generally appreciated that we are being irradiated all of the time from several sources. Cosmic radiation goes on 24 hours a day, but the actual dosage received depends on where you are. At sea level, it would be approximately 35 mr per year while at one mile altitude, exposure approximates 55 mr per year. Other natural sources of radiation are building materials and the ground. At a given point on the surface of the ocean (which

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may be considered to be base line) 35 mr per year are emitted. The usual materials in a building can be expected to give off 60 to 100 mr per year. Exposure within some houses, as demonstrated in a Swedish study, amounts to 200 to 300 mr per year.

Other sources of low level radiation include natural potassium in our own body and exposure to other peoples' natural potassium in a crowd. This would yield 20 mr/year and 2 mr/year respectively. Radium adds up to 100 mr/year and carbon^{14} 1-2 mr/year. Older television sets and radiolucent watch dials contribute small exposures. It might be pointed out that radioactive fallout from nuclear bomb testing to date has contributed only a fraction of 1 mr per year to our total exposure.

Thus the average minimum radiation exposure per year is 100-150 mr, but the figure varies with location. While it may approximate 100 mr per year in Chicago, it probably is closer to 200 mr per year in Colorado.

There is good evidence that the rate at which mutations occur is directly proportional to the radiation dose to the gonads. Mutations are probably recessive in nature and do not express themselves for several generations. This is one reason why documentation of genetic effects of radiation in man is difficult. Radiologic procedures (chiefly diagnostic) contribute an average dose to the gonads in man in excess of natural radiation, which probably is in the range of 20-100 mr per year.

There are other mutagenic influences besides radiation, which probably accounts for only 10 per cent of all mutations. A low dose of 25 r in fruit flies has produced mutations. It is possible that a radiation dose of 50 r, either as a single dose or distributed over a lifetime may double the natural mutation rate in man. Since this rate is not precisely known for the past, it is difficult to evaluate the significance of doubling it.

Mutations have been effective in adapting man to his enviroment, however, and if we consider that we are at an optimum state now, then an increase is likely to result in poorer adaptation of man to his present environment. Since most mutations are recessive, no effect usually is noted until interbreeding fuses two such recessive genes. Sometimes the recessive form can be shown to be advantageous to the organism; sickle-cell anemia, in its recessive form, confers resistance to malaria, perhaps explaining the persistence of this gene in tropical areas.

Surveys comparing the incidence of leukemia in radiologists with that in a control group of physicians not habitually exposed to radiation showed leukemia more common in radiologists by a factor of at least five. Life tables also purport to show that radiologists on the average live five years less than other physicians. Such statistics are difficult to interpret since much depends upon the age at which physicians begin to practice their specialties. At present, life shortening must be considered questionable.

Does every ionization contribute to shortening of the life span? Experiments with small animals reveal that below 100 r, no differences are noted between irradiated and nonirradiated animals. Above 100 r, there appears to be a decreased life span.

The incidence of leukemia appeared to increase with larger radiation dosages. The adverse effects at Hiroshima and Nagasaki were dependent upon the distance of the recipient from ground zero. At a distance of 1,500 meters the dose was 120 r, but fell to 20 r at 2,000 meters. British investigators studied a group of patients who received X-ray therapy for ankylosing spondylitis. Approximately 40 cases of leukemia were found in this group. There appeared to be a direct relationship between the development of leukemia and X-ray exposure above 500 r. In another study in the United Kingdom currently in progress, the incidence of leukemia in children below age 10 is being determined. There appears to be no significant difference between youngsters who received irradiation in infancy and a control group, but in somewhat less than 40 cases of leukemic children, the mothers had received X-ray pelvimetry during gestation, as against an expectancy of about half as many cases. The average X-ray dose involved was estimated as 2.5 to 4.0 r, but this cannot be established positively.

It has been widely suggested that leukemia, as a somatic mutation, may occur in direct proportion to the dose of radiation. This theory has not been proved and there are many reasons why it does not appear likely. As with genetic mutations, however, direct proof, either experimental

or from human statistics, could hardly be obtained at radiation doses comparable to the natural background.

Dr. Roger A. Harvey, Professor of Radiology: The Shields Warren study of the incidence of leukemia in radiologists is being criticized as it was unduly weighted to include a high percentage of early workers in the field who received high exposures for many years before it was generally known that radiation could be harmful.

Dr. Ford K. Hick, Professor of Medicine: Is all leukemia due to ionizing radiation?

Dr. Brues: No, other leukemogenic agents have been described: benzol in man, and estrogens and some hydrocarbons in mice.

Dr. Robert Adolph: Should we not question all women in the childbearing age as to the date of their last menstrual period before ordering a lower G.I. series, considering the possible large gonadal and/or fetal exposure? What is the probable gonadal dose from a barium enema study?

Dr. Brues: Radiation of mice during the estrous cycle can produce a decreased litter size.

Dr. Harvey: Usual fluoroscopic equipment and technique in a complete lower G.I. survey may involve 7 to 9 r. Some clinics will not do a barium enema until just after menstruation.

Dr. George Gee Jackson, Associate Professor of Medicine: What is the effect of X-ray on the ovaries?

Dr. Harvey: Some investigators have maintained that a small dose X-ray has a "stimulating" effect on these organs.

Dr. George A. Saxton, Jr., Associate Professor of Preventive Medicine: If X-ray radiation to rats produces leukemia, what about other radioactive elements such as strontium^{90}, a product of hydrogen bomb testing?

Dr. Brues: There is little experimental work in animals using strontium^{90} to answer your question. Certainly, we know that leukemia is a less likely effect of strontium^{90} than bone neoplasm. It is well to remember the importance of factors other than radiation exposure, such as tissue responsiveness.

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Hay fever

Ten of 13 patients suffering from seasonal pollinosis presented themselves for the first time during the pollen season. They were suffering acutely from lacrimation, conjunctivitis, rhinorrhea, sneezing, and nasal obstruction and were not relieved by the use of antihistaminics, eyedrops, nosedrops, or other symptomatic treatment. The remaining three patients were undergoing specific treatment for pollinosis and suffered relapses during the season. Relief of symptoms in all 13 children resulted from the use of prednisone in 24-48 hours. It was necessary to give the 10 patients suffering from seasonal hay fever, who had not received desensitization previously, maintenance doses of 5-10 mg. of prednisone per day for five to seven days and a few, as long as 14 days while treating them co-seasonally with small amounts of intradermal antigens. This somewhat longer period of treatment did not result in any apparent side effects. *Samuel J. Levin, M.D. and Philip Adler, M.D. Prednisone in the Treatment of Allergic Diseases in Children, A.M.A. Am. J. Dis. Child. Feb.* 1958.

Nausea in Pregnancy: Some Psychosomatic Relationships

HARRY L. SENGER JR., M.D., CHICAGO

IT is widely believed that emotional factors play an important role in the nausea many women suffer from during pregnancy. This paper presents the results of a pilot investigation concerning these beliefs.

Two hundred eighty consecutive pregnant clinic patients filled out an anonymous self-explanatory questionnaire dealing with their reactions and feelings about pregnancy and certain psychosocial aspects of life. The patients were divided approximately into thirds with regard to nausea. Seventy three women (26.1 per cent) reported *no* nausea in pregnancy; 109 women (38.9 per cent) reported *moderate* nausea; and 98 women (35.0 per cent,) *severe* nausea.

The answers given by the group reporting no nausea were compared with those reporting severe nausea. Some differences were found which were unlikely to have occurred by chance. ($p<0.05$) A study of these differences suggests that unconscious or preconscious personality factors may be related to nausea in pregnancy. Compared to women who reported no nausea during pregnancy, those who reported severe nausea tended to report that:

1.—Sexual relations sometimes make them feel "sick to the stomach."
2.—They have had to do considerable spitting during pregnancy.
3.—When "things go wrong" they are likely to react by "getting mad."
4.—They differ with the husband concerning whether a girl or boy baby is desired.

In addition to the four differences detailed above, women who reported severe nausea during pregnancy exhibited no suggestion that they were worried or unhappy about having a baby. In this respect, there was no difference between them and the group reporting no nausea.

It has been suggested[1] that pregnant women with severe nausea generally are unduly dependent upon their mothers or are adverse to sexual intercourse in some way. Contrary to these beliefs we found in our group that the patients, in general, neither lived with nor visited their mothers daily. Moreover, they reported that their sex desire was approximately equal to that of their husbands, and that they usually reached a climax during intercourse. In these respects, there was no difference between the group reporting severe nausea and women reporting no nausea.

The population of this study consisted of clinic patients — poorly educated lower economic strata; 90 per cent were Negro. A comparable study will be done next year with a group of private patients of the white race. In this way, the relationship of racial and economic factors to nausea in pregnancy will be investigated.

SUMMARY

Two hundred eighty consecutive pregnant clinic patients filled out a self-explanatory, anonymous questionnaire concerning their reactions and feelings about pregnancy and certain psychosocial aspects of life. The women who reported no nausea were compared to those with moderate and severe nausea. Some differences were found which were unlikely to have occurred by chance. These differences suggest that unconscious or preconscious personality factors play an important role in the nausea which many women suffer during pregnancy.

From The Department of Obstetrics and Gynecology of the University of Illinois School of Medicine, Chicago.

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Sensitivity to Fabric and Film Used for Packaging

PAUL TACHAU, M.D., ALBERT J. LEVINE, M.D., MORRIS FINKEL, M.D., AND WILLIAM I. FISHBEIN, M.D., CHICAGO

SEVEN materials used in packaging were tested to determine the frequency with which they produced allergic responses or were primary irritants. Positive reactions to the patch tests occurred in only one of almost 200 persons tested. Nylon film and cellophane are rare producers of contact allergy.

With the wide use of fabric and various types of film for packaging, it is important to determine the frequency of allergic response to these materials.

The materials tested in this study were as follows:

Sample A—Type 6 Nylon, High Caprolactam Monomer Content, Knitted Fabric

Sample B—Type 6 Nylon, Random Fine Fiber

Sample C—Type 66 Nylon, Film

Sample D—Type 6, Nylon, Film

Sample E—Type 6 Nylon, High Caprolactam Monomer Content, Film

Sample F—Type 6 Nylon, High Caprolactam Monomer Content, Film

Sample G—Cellophane, Heat Sealing Grade, Film.

METHOD

About one-half square inch of each of the seven materials to be tested was applied to the skin of the patient and covered with elastoplast. Application was made on the upper arm, the thigh, or back. The patches were left in place for two days, then removed, and the reaction, if any, noted. The area was again checked two days later. The final reading was always made four days after the material had been applied. After a period of two weeks, a second test was made, identical to the first.

The patients varied in age from 3 years to 50 years, divided fairly evenly among males and females, adults and children. Eight of those tested were suffering either from atopic dermatitis or eczema of the contact type. The tests were completed on 184 persons. On 16 patients only the first test was carried out. In testing programs on large groups of individuals, it is not unusual to have a few drop out before the program can be completed. This may occur for a number of reasons such as illness, lack of time, or change of residence.

RESULTS

In the total group of 200 patients studied, only one reaction was noted. This occurred with Type 6 Nylon Film with High Caprolactam Monomer Content, Sample F. Even in this case the reaction was only slight and not sufficient to photograph. This positive reaction occurred in the daughter of one of us.

CONCLUSIONS

It is well known that contact allergy may follow a wide variety of substances. It may be expected that in any group tested about one out of 100 may react to almost any material; hence, the reaction of one in a group of 200 to Nylon Film with High Caprolactam Monomer Content was not unexpected.

In view of the fact that a number of subjects tested were suffering from skin disorders resulting from contact allergy, the results in testing of the film would seem to indicate that allergic responses to these materials will be few.

In view of the widespread use of materials of this type for packaging, it is important that this fact be borne in mind, and packaging materials not be blamed when allergies occur due to other materials. From the standpoint of the production of either an allergic reaction the materials tested can be considered safe.

CASE REPORTS

Treatment of Burns of the Eyelids

ROBERT G. TAUB, M.D., CHICAGO

IMPORTANT objectives in the treatment of burns are prevention of infection, wound cleansing or removal of tissue debris, and prevention or minimization of scarring. Although a number of antibiotic ointments and several proteolytic debriding agents have been available for the treatment of burns, not until recently has an ointment* become available combining both antibiotics and proteolytic enzymes.

This paper presents a report on the use of this ointment in two cases of burns of the eyelids and upper face. Tryptar® ointment contains two proteolytic enzymes, trypsin and chymotrypsin; and two antibiotics, polymyxin and bacitracin. The enzymes have a natural gift of digesting necrotic tissue without affecting viable tissue. Topical use of trypsin has been well documented. Reiser et al.[1] found it a valuable aid in treating sloughing wounds. Morani[2] states that trypsin is a highly satisfactory debriding agent, providing rapid, selective, and non-toxic action. Chymotrypsin has much the same properties and combined with trypsin, appears to have an added or augmented action.

Clinical Assistant in Ophthalmology at Northwestern University Medical School; Attending Ophthalmologist, Columbus Hospital, Chicago and Doctors Hospital, Michigan City, Indiana; Assistant Attending Ophthalmologist, Children's Memorial Hospital.

*Tryptar Ointment was supplied by the Armour Laboratories.

Since clean wounds heal properly, it is advantageous to have available topical agents that can clean the wound safely and effectively by digesting the products of tissue injury. Removal of dead tissue reduces the potentials of infection, since dead tissue frequently acts as a medium for bacterial invasion and growth.

Debridement by trypsin and chymotrypsin prepares the wound for maximal action by the topically applied bacitracin and polymyxin. Bacitracin is effective against gram positive bacteria and a few gram negative bacteria. Polymyxin is active against many gram negative bacteria. Selection of these two antibiotic agents is predicated on their ability to withstand inactivation by products of bacterial growth, their relative freedom from allergic reactions, and their effectiveness against organisms commonly found in skin lesions. The enzymes and antibiotics are combined in a special base, which provides ease of application and prevents enzyme loss.

Burns of the face, particularly about the eyes, require special attention because infection and poor healing result in the formation of a scar. Scars of the face and eyelids are not only disfiguring but may interfere with function. The following cases indicate the usefulness of Tryptar ointment for the treatment of burns of the face and eyelids:

P. B., a 25 year old male, suffered a severe

electrical burn, involving the skin of upper and lower lids on September 14, 1956. When the patient was first examined, I noted severe edema of the lids, extending down into the cheeks. The left cornea was opaque. The lids covered the globes satisfactorily and blepharorrhaphy was not indicated. Tryptar ointment was applied to the skin of the lids twice daily from September 14th through September 22. In addition, a 10% sodium sulfacetamide ointment was instilled in the left eye daily. The burns of the lids responded nicely to treatment, there was no secondary infection, and the debriding proceeded rapidly. The patient did not complain of pain during the treatment. At the time of dismissal on September 25, there was no residual scarring of the lids, no cicatricial ectropion or entropion, and no skin graft or secondary plastic repair was necessary. The corneal opacity had cleared by the time of dismissal.

R.S., a 43 year old male, was hospitalized on February 13, 1957 because of thermal burns of first and second degree involving the skin of both upper and lower lids and portions of his face and hands. He had several large bullae on the lids and the face. Tryptar ointment was applied to the exterior surface of the eyelids from February 13 through March 2. The lids responded promptly to treatment and no secondary infection developed. The burns on the other portions of his face were used as a control and were not originally treated with Tryptar ointment. They did not respond as speedily to conventional measures and, therefore, on February 22, Tryptar ointment was applied. The burns immediately improved and the odor and discharge quickly cleared. He was dismissed from the hospital March 16, 1957. There were no contractures of the lids and no residual scarring. This patient was seen again in August of 1957. The facial burns had healed completely with minimal scarring. There was no cicatricial ectropion or entropion. There was a small area on the left wrist which requiring grafting but the burned areas on the hand had not been treated with Tryptar ointment.

SUMMARY

1. Two patients with burns of the eyelid were treated with Tryptar ointment, an agent that has wound cleansing properties in addition to antibacterial action.
2. The burns healed rapidly.
3. The second patient was used as a control; the burn that was treated with the ointment healed more readily than the burn originally treated conventionally.
4. There was no scarring and plastic repair was not necessary.

6 N. Michigan Av.

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This is fame

Physicians get neither name nor fame by the pricking of wheals, or the picking out of thistles, or by laying of plaisters to the scratch of a pin; every old woman can do this. But if they would have a name and a fame, if they will have it quickly, they must do some great desperate cures. Let them fetch one to life that was dead, let them recover one to his wits that was mad, let them make one that was born blind to see, or let them give ripe wits to a fool—these are notable cures, and he that can do this, and if he doth thus first, he shall have the name and fame he deserves; he may lie abed till noon.—*Paul Bunyan*

Pseudomonas Pyocyaneus Cholangitis

R. A. Shapiro, M.D., J. H. Sloan, M.D., and S. L. Goldberg, M.D., Chicago

THE bacterium, Pseudomonas pyocyaneus, is an uncommon etiologic factor in suppurative cholangitis. In the series of Cook, et al.[1], this organism was present in only two of 90 cases. This incidence probably is higher where an abnormal communication exists between the biliary and gastrointestinal tracts[2,3]. The organism most commonly causing suppurative cholangitis is Escherichia coli. Other bacteria commonly found in the diseased biliary tract are Aerobacter aerogenes, Proteus vulgaris, the enterococci, and the clostridial organisms.

Until recently, the treatments of cholangitis consisted of the removal of foreign and obstructive material (such as gallstones) from the biliary tract to provide internal drainage, and providing external drainage through a T-tube or a catheter. Much has been added to treatment by the recent and continuing addition of a variety of new antibiotic agents, plus the constant improvement of techniques that permit rapid and accurate evaluation of sensitivities of organisms to these antibiotics.

Recently, we encountered a patient in whom external and internal biliary drainage were not sufficient for the cure of cholangitis due to Pseudomonas pyocyaneus and specific antibiotic therapy was used in an attempt to sterilize the bile. The help this gave the patient and the relationship of a rubber T-tube to the final eradication of the organism proved interesting. We could find no similar case reported in the literature and believe our experience is worthy of report.

D. L., a 66 year old female, in October, 1954, began to have intermittent episodes of chills and fever, the latter ranging as high as 104 degrees F. These attacks lasted 12 to 36 hours and appeared in the beginning at two to three week intervals. There were no other symptoms and continued observation revealed no reason for these episodes. The febrile spells recurred at more frequent intervals for nine months and then, in July, 1955, right upper abdominal pain appeared with chills and fever. This led to specific diagnostic studies that established a diagnosis of calculous gall bladder disease. She was subjected to a laparotomy—cholecystectomy and choledochotomy—at another hospital. The common bile duct was drained and the patient was afebrile and symptom free until a direct choloangiogram was performed prior to her discharge. Following quickly upon this cholangiogram, fever recurred without pain or jaundice. She was discharged from the hospital with the T-tube in place.

On November 2, 1955, she was admitted to Michael Reese Hospital during a stage of subsidence of a febrile bout. Her rectal temperature was 102 degrees F. and her pulse rate was 80. The white blood count was 11,500 and 78% of the white cells were polymorphonuclear leucocytes. The only physical findings were enlarged nodular thyroid gland, a T-tube in situe, and slight hepatic enlargement.

Intensive laboratory study was not helpful. Liver function studies, blood cultures, and bacterial blood agglutinations were normal. Serum amylase levels were normal and pancreatic enzymes were present in the stool. An L. E. preperation was normal. Chest X-Ray showed a tracheal deviation due to the enlarged thyroid and radioiodine studies and B. M. R. determinations were essentially within normal limits. There were a few casts in the urine and a gamma streptococcus was cultured from the urine.

A direct cholangiogram showed a negative shadow adjacent to the proximal limb of the T-tube. There was no sign of biliary tract obstruction as evidenced by rapid emptying of the injected dye into the duodenum and by the absence of dilatation of the biliary tree. Bile culture showed a mixed flora with Pseudomonas pyocyaneus predominating. Coliform bacilli, Aerobacter aerogenes, and enterococci

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were found also. Pseudomonas was the predominant organism in the stool cultures.

As a first step in therapy, chloromycetin was chosen empirically. One-half gram was given four times daily for 10 days. There was no effect on the febrile course of the disease. Laparotomy was performed 19 days after admission. Exploration of the common duct revealed that the cholangiogram shadow was due to bile salts precipitated on the T-tube. No other stones were found. Fresh cultures of the common duct bile were taken and a new T-tube was placed in the duct. A liver biopsy was taken prior to closure. The organisms cultured (not significantly different from those grown out previously) were submitted to sensitivity tests for various antibiotics. Liver sections showed "organizing peri-hepatitis, peri-cholangiolitis, and degenerating and regenerating liver cells." The patient's recovery from surgery was without event, except for the fact that her febrile status was not greatly improved.

Several days postoperatively, we obtained a quantity of streptonovicin monosodium (Albamycin®), an antibiotic supplied by the Upjohn Company. This product is secreted in the bile in large amount and most strains of Pseudomonas pyocyaneus are sensitive to it in vitro. We administered this substance empirically, before the sensitivity studies had been completed, in doses of 500 mg. every six hours. There was no significant effect on the patient's febrile course after six days of therapy. We found that the concentration of Albamycin® in the bile was between 500 and 600 micrograms per cc. of bile, but the organism was not sensitive to the drug even in vitro. Sensitivity studies, when completed, showed that the Pseudomonas was moderately sensitive to Neomycin®, and to no other antibiotic tested. By this time, our bile cultures showed a virtually pure culture of this organism. Accordingly, on the tenth postoperative day, Neomycin was started intramuscularly in doses of 125 mg. twice daily. Irrigation of the bile duct directly through the T-tube was begun simultaneously. Ten cc. of a 0.5% solution of Neomycin was instilled four times daily. Within 48 hours the bile became much clearer and lighter. This regimen was continued for three days and was terminated because of the development of a diffuse macular rash about the head, neck, torso, and upper extremities. The patient's temperature had dropped to 100 degrees F. rectally and never rose above that figure during the rest of her hospital stay, a period of some two weeks. Gantrisin® was given for three days after Neomycin was stopped. The rash disappeared, and Neomycin was restarted, 125 mg. b.i.d. intramuscularly and was continued through the hospital stay without ill effects.

About a week after the Neomycin was restarted the patient was better than she had been since the onset of her illness. She looked well, felt well, and was afebrile and ambulatory. She could tolerate prolonged closure of the T-tube very well. However, fresh bile cultures taken during this period of clinical well being, still showed Pseudomonas, but in decreasing quantities. Recalling the frequent association of Pseudomonas pyocyaneus infection with the presence of rubber drainage tubes, we began to speculate whether the presence of the rubber T-tube was contributing to the persistence of the positive cultures. On the 24th postoperative day, the T-tube was removed. The fistulous tract was dry in 24 hrs. The patient continued afebrile and well and was discharged eight days later on the thirty-second postoperative day. Three months later she was in fine general condition. Fever had not recurred, liver function tests were normal, and stool cultures showed no evidence of Pseudomonas pyocyaneus.

SUMMARY

A case is presented of suppurative cholangitis with Pseudomonas pyocyaneus as an etiologic factor. The role of cultures and sensitivity tests with use of proper antibiotic therapy (in this instance, Neomycin) as an adjunct to adequate surgical measures in the treatment of this condition is discussed. The affinity of Pseudomonas pyocyaneus to rubber drainage tubes is reaffirmed, and cure is reported following the removal of the tube and antibiotic therapy.

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Pathology Conferences

Erythremic Myelosis

FRANCIS J. TENCZAR JR., M.D., CHICAGO

FIRST Admission (January 1957): A 63 year old white female entered the hospital complaining of weakness and tiredness for six months, shortness of breath, and palpitation for three months, and nocturnal dyspnea for three weeks. She also had noted some abdominal discomfort but upper and lower gastrointestinal studies were reported normal. Ecchymoses occurred over arms and shoulders. During the six months before admission she received 2 units of blood because of weakness.

Physical examination revealed a temperature 99.4° F.; pulse 100; respirations 20; blood pressure 154/78 mm. Hg. There were a few cutaneous ecchymoses. The head and neck were not remarkable, no superficial lymph nodes were palpated, and the lungs were normal. The heart was enlarged and a soft systolic murmur was audible over the aortic and pulmonic areas. The liver and spleen were palpated 2-3 cm. below the costal margins. There was no peripheral edema.

Urinalysis on admission was normal. The hematocrit was 22%; hemoglobin, 7.5 grams per 100 ml.; red count, 2.8 million; white count, 2,350; differential, 21 segmented and 10 unsegmented neutrophils, 55 lymphocytes, 2 monocytes, 7 eosinophils, and 5 basophils; reticulocyte count, 4.1%; platelet count, 60,000 per cu. mm. Moderate anisocytosis and polychromatophilia were apparent in the peripheral blood film. A sternal marrow aspiration (Figure 1)

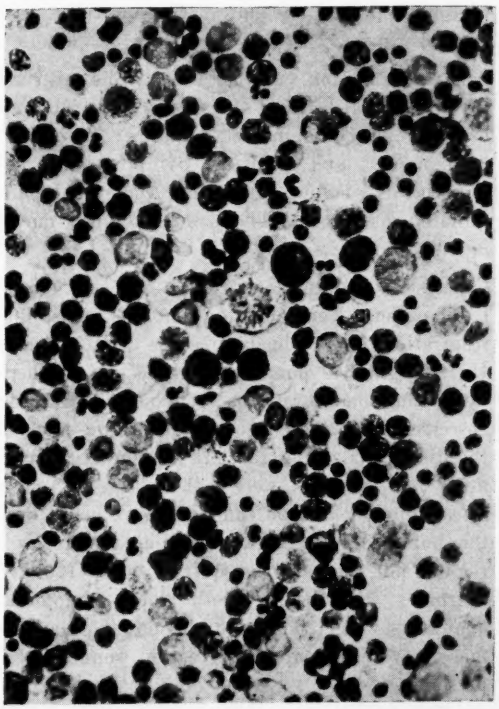

Figure 1. Photomicrograph of aspirated sternal bone marrow smear. Darkly staining erythroblasts predominate. Early abnormal erythroblasts have large nuclei. The paler staining myeloid cells are promyelocytes or myelocytes and segmented granulocytes are scarce. Wright-Giemsa stain. 700x.

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showed marked erythroid hyperplasia with a preponderance of immature erythroid cells. The direct Coombs test was negative.

The patient received 6-Mercaptopurine, cortisone, and 9 units of blood. The hematocrit increased to 38%. The white and platelet counts were unchanged. She improved markedly and was discharged on the 11th hospital day while still receiving 6-Mercaptopurine and cortisone.

Second and Third Admissions: The patient was readmitted to the hospital two and four months after the initial admission because of recurrence of anemia, dyspnea, and weakness. Physical examination was unchanged. The white count ranged from 1,500 to 2,000. A differential count included 15 segmented and 16 unsegmented neutrophils, 57 lymphocytes, 3 monocytes, 3 eosinophils, 2 basophils, 2 "blast" cells, and 2 promyelocytes. There was 1 normoblast per 100 leucocytes. She received a course of aminopterin and numerous transfusions with marked symptomatic improvement. Cortisone was administered without interruption throughout her illness.

Final admission (*August* 1957): She returned to the hospital because of a severe chill followed by fever and accompanied by upper abdominal pain, nausea, and vomiting. Symptoms had begun the day before admission. Abdominal pain radiated to the back. There were no bowel movements for 2 days.

Physical examination revealed an obese, acutely ill patient. Temperature 103.2° F.; pulse 96; respirations 24; blood pressure 100/70 mm. Hg.; weight 240 pounds; height 5′ 5½″. There were numerous cutaneous ecchymoses. Draining abscesses were present over the coccyx and on the distal phalanx of the left thumb. The superficial lymph nodes were not enlarged. A few rales which cleared on coughing were heard over the pulmonary bases. The cardiac rhythm was regular but the rate varied from 96 to 120. No murmurs were heard. Both upper abdominal quadrants were tender. No abdominal organs or masses were palpated and bowel sounds were present.

Laboratory examinations revealed a normal urinalysis; hematocrit, 30%; hemoglobin, 10.2 grams per 100 ml.; white count, 6,450; platelet count, 270,400; reticulocyte count, 0.3%; serum amylase, 8 units. Serum electrolytes (mEq./L.) were: sodium, 129; chloride, 50; potassium, 4; carbon dioxide combining power, 20. A culture of one of the abscesses yielded a heavy growth of Escherichia coli and lighter growths of Streptococcus fecalis and Staphylococcus albus. A blood culture was negative in 48 hours. An electrocardiographic tracing showed atrial fibrillation with a rapid ventricular rate.

The patient was treated with parenteral tetracycline and penicillin as well as cortisone and ACTH. The temperature declined rapidly to normal but the day after admission rales were heard over the right upper lobe and bronchial breathing was noted over the left apex. Her condition worsened rapidly and she died 24 hours after admission.

CLINICAL DISCUSSION

*Betty M. Hahneman, M.D.**: Today's case concerns a 63 year white female who entered the hospital complaining of weakness, tiredness, shortness of breath, palpitation, and nocturnal dyspnea. Before hospitalization, X-rays of the gastrointestinal tract were made and she received 2 units of blood. The ecchymoses presumably represented more than the usual bruising tendency for this patient. There was no history of jaundice or exposure to toxic substances or radiation. She was apparently asymptomatic until the onset of the present illness.

Physical examination revealed only a low grade fever, tachycardia, and moderate hepatosplenomegaly without lymphadenopathy.

Laboratory studies showed a normocytic normochromic anemia, leucopenia, and thrombopenia. Examination of the peripheral blood showed anisocytosis, poikilocytosis, polychromatophilia, basophilic stippling, and a moderately elevated reticulocyte count. No macrocytes, spherocytes, target cells, or nucleated erythrocytes were present. The leucopenia was due to granulocytopenia with a left shift. Eosinophils and basophils were increased. The immature granulocytes included myelocytes, metamyelocytes, and band forms.

At this point we are confronted with the differential diagnosis of a marked pancytopenia associated with moderate hepatosplenomegaly

*Courtesy Group, Department of Medicine, Chicago Wesley Memorial Hospital; Clinical Assistant in Medicine, Northwestern University Medical School.

and morphologic abnormalities of the red and white blood cells. We have no evidence of the usual diseases causing splenomegaly — cirrhosis or other hepatic disease, lymphoma, tuberculosis, sarcoidosis, malaria, or acute infectious disease such as infectious mononucleosis. The latter is rarely accompanied by hemolytic anemia or thrombocytopenic purpura.

Apparently the clinicians initially considered the possibility of hemolytic anemia. There was no familial history and the negative direct Coombs test militated against this diagnosis. Moreover, in acute hemolytic anemia one usually find a leucocytosis and, although there might be a marked granulocytic left shift, basophilia is uncommon. One would also expect a greater reticulocytosis and the platelets usually are normal or increased.

So-called splenic pancytopenia should have been considered in view of the palpable spleen. Once again the left shift in the granulocytic series is inconsistent. This type of hypersplenism usually is secondary to another disease.

Pancytopenia may occur in the macrocytic anemias. In this case, the morphology and indices of the red blood cells, the absence of icterus, and the abnormalities of the white cells are not suggestive of pernicious anemia. Certainly this degree of pancytopenia would be uncommon. In addition there were none of the usual clinical symptoms of pernicious anemia or a spruelike syndrome. It would be unusual for a patient with a severe anemia of six months' duration not to receive sufficient vitamin B_{12} or liver to cause a remission.

Aplastic anemia: This patient gave no history of exposure to substances toxic to the bone marrow. Such a history is not, however, essential. Pancytopenia occurs in aplastic anemia but one would expect a lower reticulocyte count and less granulocytic left shift. Splenomegaly would be unusual.

The myelophthisic anemias due to replacement of bone marrow by tumor or myelofibrosis can produce this clinical picture. There was no evidence of a malignant tumor. In myelofibrosis, the degree of splenomegaly usually is greater than in this patient. Certainly the basophilia as well as the abnormalities of the granulocytes and erythrocytes are consistent with this diagnosis. More nucleated red cells usually are present in the peripheral blood.

Acute leukemia is a more likely diagnosis. Often there is a history of a refractory anemia and this patient was subleukemic when first seen. The abnormal differential count, anemia, and hepatosplenomegaly are in keeping with acute leukemia. It is becoming increasingly evident that acute leukemia should no longer be considered a disease of childhood or young adulthood.

Examination of bone marrow is the critical diagnostic test in this case. Wright-stained smears of aspirated sternal marrow revealed a hypercellular marrow with marked proliferation of early erythrocytes, including many abnormal forms. More primitive reticular or histiocytic cells, some showing characteristics of the erythrocytic series, also were present. Granulocytes were decreased and early forms—myeloblasts and progranulocytes—predominated. Megakaryocytes were decreased. I believe these findings establish the diagnosis of erythroleukemia.

Erythroleukemia, as originally described by Di Guglielmo, was a mixed erythrocytic and granulocytic proliferative process similar to acute leukemia. Erythremic myelosis indicated a pure erythrocytic proliferative process. Since Di Guglielmo's original report it has become apparent that abnormal erythrocytic proliferation often is a phase of acute leukemia. If such patients can be kept alive by various supportive measures—transfusions, steriods, antimetabolites —there often is a transition to granulocytic or monocytic leukemia. In this patient, the abnormal proliferative process involved the granulocytic as well as the erythrocytic series.

Erythroleukemia may occur at any age and many of the patients described in the literature are over 50 years. The usual findings are anemia, leucopenia, thrombocytopenia, and moderate hepatosplenomegaly. Nucleated red cells usually are conspicuous in the peripheral blood but the absence of this finding in this case does not exclude the diagnosis. One may deduce from the protocol that the attending physician also made a diagnosis of erythroleukemia or acute leukemia since the patient was treated with 6-Mercaptopurine. Moreover, on subsequent admissions, occasional immature granulocytes and nucleated red cells were observed in the peripheral blood film.

The final admission was precipitated by the

sudden onset of chills, fever, nausea, vomiting, and upper abdominal pain. There were cutaneous ecchymoses and several abcesses. Unfortunately a blood film is not available from this admission. These signs and symptoms suggest an acute abdominal episode. In view of the previous abdominal complaints and steroid medication for eight months, the possibility of a perforated gastric or duodenal ulcer should be considered.

I also believe the patient had bilateral pneumonia as indicated by the appearance of rales, bronchial breathing, and dullness over the lungs. A recent survey[1] by the National Institutes of Health included bacteriologic or clinical evidence of infection in 66 per cent of febrile patients with leukemia. The usual organisms recovered were Staphylococcus aureus and various gram negative rods. Nearly 75 per cent of fatalities during the study were attributed to overwhelming infection.

Finally, the occurrence of weakness, tachycardia, hypotension, and the serum electrolyte abnormalities suggest the possibility of acute adrenal insufficiency. This is likely to occur in a patient who has been maintained on cortisone for a long period and then experiences an acute illness.

DR. HAHNEMAN'S DIAGNOSES

1. Acute erythroleukemia.
2. Bilateral bronchopneumonia.
3. Possible perforation of peptic ulcer with peritonitis.

ANATOMIC DIAGNOSES

1. Erythremic myelosis involving bone marrow, spleen, liver, lymph nodes, heart, kidney, and skin.
2. Bilateral bronchopneumonia.
3. Hemosiderin pigmentation of liver and pancreas.
4. Dilatation and hypertrophy of heart (350 grams).
5. Ulcer of sacrum; abscess of left thumb.

PATHOLOGIC DISCUSSION

Francis J. Tenczar Jr., M.D.: At autopsy there were numerous cutaneous ecchymoses and, as noted clinically, ulcers over the left buttock and thumb. Both lower extremities showed slight pitting edema. The heart was normal except for slight hypertrophy (350 grams) and dilatation. The lungs weighed 900 grams together. Both lungs contained discrete foci of bronchopneumonia. Both the liver (2,500 grams) and spleen (600 grams) were enlarged but the normal parenchymal patterns were preserved. The vertebral marrow was soft and paler than usual. There was no perforated viscus or peritonitis to account for this patient's abdominal pain.

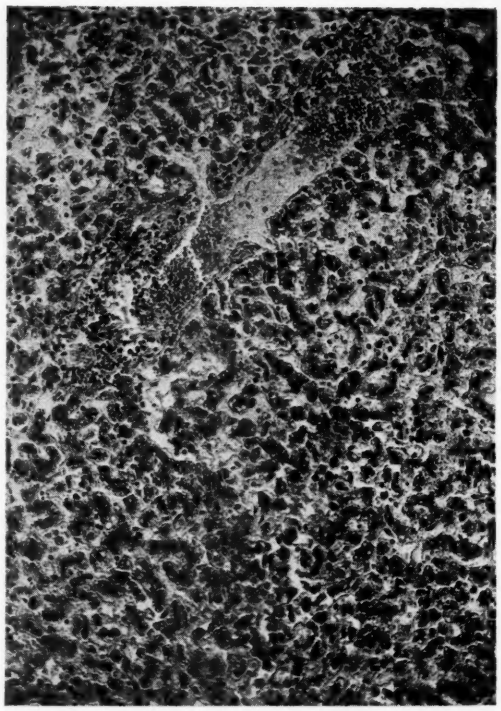

Figure 2. Photomicrograph of liver showing increased portal cellularity and occasional abnormal cells in the hepatic sinusoids. Hematoxylin and Eosin. 120x.

Microscopically the bone marrow was more cellular than normal. The majority of the cells belonged to the erythrocytic series with many immature forms. The cytologic pattern was similar to the smears of aspirated sternal marrow (Figure 1) discussed by Dr. Hahneman. Small aggregates of hematopoietic cells were encountered in the heart, kidneys, and cutaneous ulcers as well as the portal areas and sinusoids of the liver (Figure 2) and the spleen. Some of these hematopoietic cells could be identified as nucleated erythrocytes. There was moderate hemosiderin pigmentation of the liver and pancreas.

These findings are indicative of a hematopoietic disorder analogous to leukemia but involving primarily the erythrocytic series. Although there is some shift to the left in the granulocytic series, the abnormal erythrocytic proliferation and maturation predominate so markedly it is felt the diagnosis of erythremic myelosis is justified. The terminal septic course of this patient is evidenced by the bronchopneumonia and the cutaneous infections.

Erythremic myelosis is one of a group of myeloproliferative disorders characterized by a primary irreversible systemic erythrocytic hyperplasia with defective maturation. The myeloproliferative disturbances may assume several forms[2]: 1) Pure erythrocytic proliferation — erythremic myelosis; 2) mixed proliferation of the erythrocytic and granulocytic series — erythroleukemia; and, 3) a polyphasic form with initial erythrocytic proliferation being succeeded by abnormal granulocytic development or vice versa. The etiology is unknown but the most popular concepts include neoplastic and viral origins. The neoplastic nature of leukemia has been acceptable for some time. Recently the concept of a viral etiology has received support from the transmission of leukemia by bacteria-free filtrates in fowls[3]. The occurrence of different forms of leukemia in fowls inoculated from the same filtrate is indicative of a similarity in the etiology and pathogenesis of the different types of fowl leukemia and suggests that grouping these disorders in man under myeloproliferative disturbances may be justified[4].

Dr. Wilson Hartz: Diagnosis in this case was established by the bone marrow aspiration which showed an abnormal and nonfunctional erythroid hyperplasia. Treatment was chiefly supportive and any improvement probably was due to cortisone. In the myeloproliferative disorders there apparently is an abnormal proliferation of a primordial cell which may undergo differentiation in several directions — granulocytic, lymphocytic, myelocytic. The nomenclature depends on the series that is responding to the abnormal stimulus, whatever that may be.

Dr. Paul Winter: Dr. Hahneman, would you classify this case as an acute or a chronic erythroleukemia in view of the fact that the patient lived approximately 15 months after the onset of symptoms?

Dr. Hahneman: Untreated acute leukemia usually is fatal within six months. However, the degree of cellular immaturity in this case is like that encountered in acute leukemia. It is likely the preliminary observations represent a preleukemic phase manifested by refractory anemia. The patient's course also may have been prolonged by treatment with cortisone and antimetabolites.

Dr. Paul Rhoads: Is hemosiderosis a common finding in this condition and what is its pathogenesis?

Dr. Tenczar: Hemosiderin pigment of the liver in erythremic myelosis and erythroleukemia is described frequently[3]. It probably is due to defective erythrocytic maturation, with consequent failure to mobilize iron from body stores. In addition, these patients frequently receive numerous blood transfusions.

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EDITORIALS

Genetics and medicine

Unprecedented progress in the field of biochemical genetics has permitted, for the first time, a logical approach to the various inborn errors of metabolism in man. Not so long ago we regarded sickle cell anemia as just one of a series of hemolytic anemias. We knew that patients with this disease could be treated by blood transfusions, but did not have the slightest idea as to why their red blood cells sickled or why they had periodic episodes of rapid hemolysis. In 1949, Pauling and co-workers[1] made the monumental discovery that the erythrocytes of these individuals contained hemoglobin with a significantly different isoelectric point and had markedly different solubility properties in the reduced state. Pauling postulated that sickle cell anemia must represent a defect in the structure of the hemoglobin molecule, and for this work he was awarded the Nobel Prize in Medicine. More recently, Ingram[2] confirmed this hypothesis by showing that the sickle cell hemoglobin molecule differs from normal hemoglobin by having one different amine acid group among some 300 such groups making up the protein molecule.

Other discoveries of this type made it apparent that biochemical genetics had come of age and could be applied usefully at the clinical level in the diagnosis and treatment of hereditary diseases in man. The Genetic Clinic, at the Children's Memorial Hospital, was formed both to provide service for patients and to undertake research in the general area of genetics as it relates to medicine. The Clinic is supported by a grant from the Chicago Community Trust and is the only one of its type in the State of Illinois.

The Clinic meets every Tuesday afternoon in the Outpatient Department of the Children's Memorial Hospital. Its service functions are threefold:

(1) Patients with any condition of a hereditary nature are given a work-up and diagnosis is established through the aid of extensive laboratory tests.

(2) An outline of treatment is worked out for patients with hereditary disorders that are amenable to specific therapy. For example conditions like galactosemia, cystic fibrosis of the pancreas, or hemophilia, can be helped effectively. As a rule, patients are referred back to their own physicians or clinics for the institution of the recommended treatment.

(3) For parents who request it, genetic counseling facilities are available regarding the probability of the defects recurring following future pregnancies.

The research program of the Genetic Clinic is directed largely toward the better understanding of certain hereditary diseases at a biochemical level. For a number of years, we have been interested in phenylketonuria, a hereditary dis-

ease responsible for about two to five per cent of the mentally defective children in state institutions. By means of a phenylalanine tolerance test, we are able to detect which individuals among the normal population are heterozygous carriers of the abnormal genes[3]. We can thereby predict which types of matings are likely to produce affected offspring. Workers in England and in this country recently have shown that mental deficiency in this disease can be prevented if affected children are treated by a special diet free of phenylalanine, if started early in infancy[4].

David Yi-Yung Hsia, M.D.
Director, Genetic Clinic
Children's Memorial Hospital

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Raleigh C. Oldfield installed as State Society president

Dr. Raleigh C. ("Barney") Oldfield, practicing physician in Oak Park for the last 43 years, was installed as president of the Illinois State Medical Society at the concluding session of the House of Delegates.

Dr. Oldfield succeeded Dr. Lester S. Reavley of Sterling, who served with distinction for the last year.

Born in Chicago, December 9, 1892, Dr. Oldfield obtained his M.D. degree from Loyola University, Chicago, in 1915. He interned in the West Suburban Hospital, Oak Park, joined the staff there, and has been associated with the hospital ever since. He is secretary of the board of trustees and member of numerous hospital committees. He has been on the consulting staff of Westlake Hospital, Melrose Park, for 33 years.

Dr. Oldfield has taught surgery at the Stritch School of Medicine of Loyola University. He also has taught nurses at the West Suburban Hospital.

After his internship, he joined the Aux Plaines Branch of the Chicago Medical Society, took an immediate interest in organizational work, and has been devoting considerable time to the nontechnical side of medicine ever since. He has been a councilor of the Chicago Medical Society for more than 25 years. He has served on the Council of the Illinois State Medical Society and on many committees at state and county levels.

Dr. Oldfield also is a member of the American Medical Association, fellow of the American College of Surgeons and International College of Surgeons, member of the Oak Park Club and Oak Park-River Forest Physicians Club, is a Shriner.

He resides at 539 Jackson Avenue, River Forest, and has offices at 715 Lake Street, Oak Park.

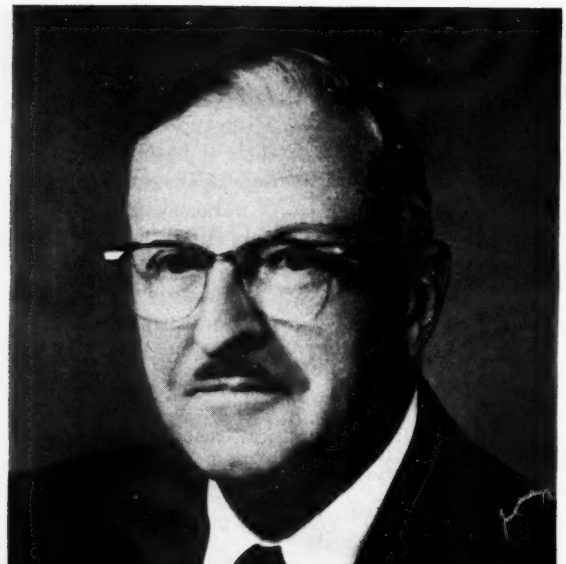
Dr. and Mrs. Oldfield have three children: Dr. Charles Oldfield of Oak Park and Hinsdale, a graduate of the Northwestern University Medical School, a cardiovascular and chest surgeon; Mrs. F. P. Spaulding of River Forest, and Mrs. D. P. Maloney of Chicago. The Oldfields have five grandchildren.

Prognosis of rheumatic carditis

The stethoscope continues to be the most important tool in the diagnosis of cardiac conditions. Feinstein and Di Massa[1] found that during an attack of rheumatic fever, the heart sounds proved extremely valuable in the prognosis. These physicians followed the clinical course of 315 children and young adults to determine what clinical features were most significant in predicting the outcome of an attack of rheumatic carditis. Monthly examinations were made and 78 per cent of the patients were studied for four years or more.

The patients were classified according to the murmurs present during the acute attack of rheumatic fever. In the series, 96 had definite evidence of valvulitis and 63 (66 per cent) of this group now have rheumatic heart disease. "Probable valvulitis" was the designation in 52 patients who developed a questionable diastolic murmur or a loud apical systolic murmur radiating to the axilla without a diastolic murmur. Of this group, 15 (29 per cent) now have heart disease.

1. Feinstein, Alvan R. and Di Massa, Rodolfo: Clin. Res. 6: 220 (April) 1958.



Raleigh C. Oldfield, M.D.
President, Illinois State Medical Society
1958-1959

"No valvulitis" was the diagnosis in 167. These patients had none of the criteria for valvular involvement although many had a systolic murmur, prolonged P-R interval, gallop rhythm, changes in cardiac size, or other features of rheumatic carditis. None of these patients has evidence of heart disease today.

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An editorial from other journals—

Trends in medicine

As our medical antennae have become ever more sensitive to the causes of illness and accidents, we are aware that scarcely an illness lacks its emotional component. We have become correspondingly aware that more and more organic illnesses have roots in emotional causes. The bottled-up hypertensive, the ulcer patient who swallows his anger, the attention-getting asthmatic or arthritic, or the rejecting and rejected colitis problem are examples of emotionally caused illness. We are not yet willing to attribute all cause to emotions, for powerful still are bacteria, metabolic abnormalities, and new growths. More and more, however, we accept the mind and spirit as powerful etiologic agents in illness.

Stress is a popular word and a good one. It is stress of work, ambition, fear, and insecurity which we believe causes ulcer or colitis. It is the stress of self-containment and fear which may cause hypertension. Possibly it is the stress of conflict between ambition and accomplishment, between creative talent and expression, which causes arthritis, dermatitis, and allergies. Though there are many still unwilling to accept completely the idea that stress may be the principal cause of an illness, yet most physicians agree that it is a large and vital factor.

We should not eliminate stress from our lives even were it possible to do so, for stress is a necessary spur to achievement and essential to accomplishment. There is stress which is productive, and that which is futile. Stress may become distress. When accomplishment decreases under stress, when physical symptoms appear because of it, then we must decrease the load or run the risk of organic illness.

All of us know individuals whose days are crammed with excitement, problems, decisions, haste and hurry, uncertainty, and tension. Yet they seem serene and remain robust and well, carrying these burdens indefinitely. Stress is the ingredient in their lives which makes such activity possible and keeps them productive to the point of genius, but stress is not distressing. Others of our acquaintance buckle at the smallest decisions and are exhausted by the mildest deviation from routine. Major decisions and emotions are impossible for them. Distress is ailing them, and eventually will obtrude as an organic lesion susceptible to pathologists' classification.

Faith is the factor least measurable in man's total health, yet perhaps most crucial. Faith has literally moved mountains, and there are thousands of patients to testify to the curative power of true faith. Man must have faith to live a full life and without faith life becomes meaningless. No physician has not witnessed the power of faith, and no physician can afford to ignore this tremendous aid in his therapy. We all want and need faith; it is part of the whole man, but often it must be learned. Do I imply that the examining doctor should hold a religious catechism in his periodic examination? Certainly not. But neither do I believe that faith can be ignored as "belonging only to the church." Knowledge of an individual's faith or absence thereof often is of great help in care, and faith must neither be touted nor scorned by the physician. *Charles S. Houston, M.D. Minnesota Med. Mar.* 1958.

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Annual meeting draws large attendance

The 118th annual meeting of the Illinois State Medical Society in the Hotel Sherman, Chicago, May 20-23, drew a total attendance of 3,117. Of these, 1,844 were physicians.

Among the attractions were an outstanding scientific program, a House of Delegates meeting which considered questions with a vital bearing on the future of medical practice in this state, and scientific exhibits which were most informative.

In opening the House of Delegates, Dr. Lester S. Reavley of Sterling, president, pointed out that the delegates were convened under principles laid down by the founding fathers of this nation, that is, "equal representation in the

development of policies which are designed to express the will of the majority, if not the whole."

ACTIONS OF HOUSE

Among the actions taken by the House of Delegates were the following:

(1) Approved a recommendation that the Advisory Committee to the United Mine Workers be dissolved and a new Third Party Plan Committee be named to consider policy governing all "third party" problems.

(2) Adopted a resolution providing (a) that the Society inform the Illinois State Legislature of the need for more I.P.A.C. funds; (b) that efforts be made to renegotiate the contract with I.P.A.C., the fee schedule in particular; (c) that I.P.A.C. notify clients in writing as to the limitations of service imposed upon physicians by the commission, and (d) that in disciplinary action each accused physician shall receive a hearing before three of his colleagues in an effort to solve problems on a local level.

(3) Approved a resolution that "the AMA instruct its representatives on the Joint Commission on Accreditation of Hospitals to defend and enhance the role of the physician and the county medical society in medical matters in their own community, and recommend that the county medical societies be consulted whenever possible in matters of accreditation."

(4) Condemned the practice of some hospitals in assessing medical staff members for building funds and requiring audits of staff members' financial records; resolved to present such a resolution to the AMA House of Delegates.

(5) Passed a resolution to ask the AMA to make a study of licensing practices with the aim of establishing uniformity among states recognizing reciprocity.

(6) Enlarged the voting membership of the House of Delegates by adding: (a) past presidents, (b) general officers of the AMA and members of the AMA House of Delegates from the Illinois State Medical Society, and (c) the president, president-elect, vice presidents and secretary-treasurer. This adds about 30 members by giving county societies opportunity to elect other physicians in place of these.

(7) Rejected a proposal to establish two new offices—a presiding and alternate presiding officer of the House.

PRESIDENTIAL ADDRESS

Dr. Reavley, in his presidential address before the General Assembly, said more physicians manifest a faith in God when they face trying emergencies than is admitted.

Such faith, Dr. Reavley said, often opens up the facets of usefulness by which the physician's work is more fully realized.

"No other profession has such frequent reminders that there are powers of life which transcend man's capacity to control," he said. "We know very little about its source, or when or how it comes. We can observe and measure the physiological and material concepts relating to life, but its terminus is as baffling as its beginning."

Dr. Reavley said physicians should "feel a participating partnership in God in His wise desire that all men should enjoy the abundance of a full and healthy life."

(*The complete text of Dr. Reavley's address was published in the June issue of the Illinois Medical Journal.*)

DR. OLDFIELD INSTALLED

Dr. Raleigh C. Oldfield of Oak Park was installed as president at the closing session of the House. Dr. Oldfield reminded the delegates that medicine was faced with trying problems on the legislative front.

"With many bills threatening the basic principles of medical practice already in the hopper, the profession will have to present a united front to prevent the application of shackles," he said.

"Socialized medicine has been creeping upon us steadily, making particularly rapid progress in election years when politicians have an eye out for the vote. The Social Security Act is the channel through which the movement is progressing."

Dr. Oldfield cited the Forand Bill as the most dangerous measure facing the profession as its adoption will add about 13 million social security claimants to the government medical care program, further increase the tax load, destroy private health insurance plans, complicate the practice of medicine by making it subject to political whims rather than sound medical principles, and jeopardize the whole economic structure of the country.

He warned that other situations bear watching

as they may affect the traditional free choice of physicians. These include Medicare and VA medical care. He also said the trend in the Hill-Burton Act administration also must be watched.

ANNUAL BANQUET

The Woman's Auxiliary worked hard to stimulate attendance at the annual banquet. As a result, a capacity audience was present to hear Dr. Carl S. Winters, minister of the First Baptist Church, Oak Park, and world traveler and lecturer give a talk on "The Doctor's Glory Road" which held everyone's rapt attention from beginning to end.

Dr. Reavley presented the Society's annual awards for distinguished lay contributions to health progress in Illinois. The individual award went to Miss Louise Hatcher of Springfield, supervisor of the medical division, Illinois Department of Registration and Education. The Illinois Health Improvement Association was presented the group award, which was accepted by Mrs. John B. Rice of Sheldon, Ill., president of the association.

Dr. F. Lee Stone, immediate past president, was the toastmaster.

SPECIAL EVENTS

Dr. Reavley, in his introduction to the House of Dr. Arthur K. Baldwin of Carrollton, chosen as the "General Practitioner of Illinois for 1958," said the honor was conferred upon Dr. Baldwin for his 34 years of service to medicine in this state.

Dr. Reavley also spoke at the luncheon of the 50-Year Club, composed of physicians with a half century or more of service. A surprise presentation was made to Dr. Andy Hall of Mount Vernon, 93, founder of the club who has 68 years of medical practice behind him.

Dr. F. J. L. Blasingame of Chicago, who this year assumed the general managership of the AMA, spoke at the annual Public Relations Dinner, arranged by the Committee on Medical Service and Public Relations.

(*A complete report of Dr. Blasingame's talk will be found on the PR Page.*)

SCIENTIFIC PROGRAM

The scientific program was an outstanding one, consisting of General Assembly sessions and sectional meetings. Nationally known speakers from all parts of the country presented papers on subjects which covered every important facet of medicine.

Dr. Alexander Marble of Boston, assistant clinical professor of medicine at the Harvard Medical School, gave the annual oration in medicine. Dr. Keith S. Grimson of Durham, N.C., professor of surgery at the Duke University School of Medicine, presented the oration in surgery.

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Dr. Joseph T. O'Neill named president-elect

Dr. Joseph T. O'Neill, pediatrician of Ottawa, was chosen president-elect of the Illinois State Medical Society at the 118th annual meeting.

Dr. O'Neill has displayed keen interest in the economic side of medicine ever since he entered his specialty 31 years ago and is especially qualified to assume the presidency of the Society. He became a member of the Council in 1948 and in 1955 and 1956 served as its chairman.

He was born in Boston in 1892. After obtaining his M.D. degree from Loyola University School of Medicine in 1916 he served as a lieutenant in the Army Medical Corps. After World War I, he took up general practice in Joliet. Because of his interest in children, he took postgraduate courses in pediatrics in Europe. In 1927, he began the practice of that specialty in Ottawa, where he has lived since.

Dr. O'Neill was named as one of the original members of the Maternal Welfare Committee of the Illinois State Medical Society when it was formed 25 years ago.

Having approached his specialty through general practice, Dr. O'Neill knows the problems of the GP as well as the specialist.

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Scientific awards made at annual meeting

The following scientific exhibit awards were made at the 118th annual meeting of the Illinois State Medical Society:

For educational value: Gold medal, Frederick H. Falls and Charlotte S. Holt, Illinois State Department of Public Health. Silver medal, John M. Coleman and Garth F. Tagge, Mercy

Hospital, Stritch School of Medicine of Loyola University, and Vaughn Medical Group. Bronze medals, George Z. Wickster and Joseph R. Christian, Stritch School of Medicine; John R. Tobin, Cook County Hospital; Donald S. Miller and Rowlin Lichter, Chicago Medical School and Cook County Hospital.

For original work: Gold medal, Alvin L. Watne, Stuart S. Roberts, Ruth G. McGrath, Elizabeth G. McGrew, and Warren H. Cole, University of Illinois. Silver medal, Sean Mullan and William Ironside. University of Chicago. Bronze medals, Cleveland J. White, Stritch School of Medicine; Theodore Cornbleet and Ruven Greenberg, University of Illinois College of Medicine; Walter S. Moos, Radiation and Medical Physics Society of Chicago.

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Dr. Gundersen installed as president of AMA

A neighbor and good friend of Illinois medicine, Dr. Gunnar Gundersen, 61 year old surgeon of LaCrosse, Wis., is the new president of the American Medical Association.

Dr. Gundersen was born in LaCrosse in 1897 and began the private practice of medicine in 1922 as an associate of his father. He now operates the Gundersen Clinic, along with three of his physician brothers, Drs. Sigurd B., Alf H., and Thorolf E. Two other physician brothers, Dr. Trygve Gundersen and Dr. Sven M. Gundersen, are practicing in Boston and Hanover, N.H., respectively.

The Gundersen Clinic, which handles 3,000 to 4,000 new patients a year, was established in 1927. It attracts people from all over the United States and is operated in conjunction with the LaCrosse Lutheran Hospital next door. In memory of their father, the Gundersens established the Adolf Gundersen Medical Foundation in 1945. This nonprofit organization grants fellowships to young physicians for advanced study in specialized fields, provides facilities and modern equipment for such studies, conducts investigations into the many unsolved problems of medicine and surgery, and provides free diagnostic services to indigents with complex medical problems.

Dr. Gunnar Gundersen is a past president of the State Medical Society of Wisconsin and Wisconsin Board of Health; former chairman of the AMA Board of Trustees and Joint Commission on Accreditation of Hospitals, and former member of the University of Wisconsin State Board of Regents.

He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons and International College of Surgeons, and a member of the Council of the World Medical Association and Public Health Association.

Dr. and Mrs. Gundersen have two sons, also physicians, and a daughter.

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Dr. B. E. Montgomery elected Council chairman

Dr. Burtis E. Montgomery of Harrisburg was elected chairman of the Council of the Illinois State Medical Society, succeeding Dr. H. Close Hesseltine of Chicago, whose two-term limit expired.

Dr. Montgomery was born in Princeton, Ind., in 1898, and obtained his M.D. degree from the University of Illinois College of Medicine in 1933. He interned in St. Luke's Hospital, Chicago, and then took up the general practice of medicine in Harrisburg in 1934.

He has served on the Council for seven years. He also is secretary of the Saline County Medical Society.

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Illinois State Medical Society election results

The results of the annual election of officers were as follows:

President-elect, Dr. Joseph T. O'Neill, Ottawa; first vice president, Dr. Lorne W. Mason, Evanston; second vice president, Dr. Paul P. Youngberg, Moline; secretary-treasurer, Dr. Harold M. Camp, Monmouth.

Councilors, Drs. H. Close Hesseltine and John L. Reichert, Chicago; Fred C. Endres, Peoria; Jacob E. Reisch, Springfield; Arthur F. Goodyear, Decatur; Harlan English, Danville, and George E. Kirby, Spring Valley. The Council elected Dr. Burtis E. Montgomery, Harrisburg, as chairman.

Delegates to the AMA, Drs. Percy E. Hopkins, Warren W. Furey, and Carl F. Steinhoff, Chicago; C. Paul White, Kewanee, and Burtis E. Montgomery, Harrisburg. Alternate delegates, Drs. Maurice M. Hoeltgen, Leo P. A.

Sweeney, and Norris J. Heckel, Chicago; Harry E. Mantz, Alton, and Lester S. Reavley, Sterling.

Medico-Legal Committee, Drs. Leo P. A. Sweeney, Chicago, and F. E. Bihss, East St. Louis. Committee on Medical Education and Hospitals, Drs. George F. O'Brien and Kenneth C. Johnson, Chicago, and Ward Eastman, Peoria. Committee on Medical Benevolence, Dr. Norman L. Sheehe, Rockford. Committee on Medical Testimony, Drs. Joseph H. Chivers, Chicago, and Peter C. Rumore, Effingham. Grievance Committee, Drs. Arkell M. Vaughn, Chicago, and Willis I. Lewis, Herrin.

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Medicine on postage stamps

Recent issues of postage stamps of interest to physicians collecting medical topics include the following:

China (Nationalist)—Three stamps commemorating the 10th anniversary of the World Health Organization show the staff of Aesculapius on the UN symbol background.

Colombia—A 5c Red Cross issue shows nurses placing stretcher patient in an ambulance.

Cuba—Four physicians are shown on a Famous Men series: Dr. Tomas Romay, 2c; Dr. Angel A. Aballi, 4c; Dr. F. Gonzales del Valle, 10c; and Dr. V. Antonio de Castro, 14c.

Dominican Republic—The double-bar Lorraine Cross is shown on a 1c postal tax stamp to raise funds to fight tuberculosis. Its use on letters was obligatory during April.

Finland—Three Finnish flowers used in medicine—Anemone hepatica, Trifolium pratense, and Convallaria majaris—are the motifs for a set of three TB semipostals.

French Equatorial Africa—The Brazzaville office of the World Health Organization is shown on a 20f stamp commemorating the 10th anniversary of WHO.

Guatemala—A four value set—1c to 4c—has been issued for the benefit of the Red Cross.

Laos—Four Red Cross stamps show a woman suckling her child.

Luxembourg—Three stamps to commemorate the 13th centenary of the birth of Sr. Willibrord, founder of the Abbey of Echternach, illustrate his healing powers.

Netherlands Antilles—Dutch birds are shown on four semipostals, the surtax of which will provide funds for child welfare.

Romania—A 1.20 lei stamp marks 25 years of sports-physicians' activity.

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Optic neuritis

Optic neuritis from nutritional causes must be mentioned. They usually are bilateral and were found frequently among prisoners of war fed on the Japanese rice diet. The tobacco-alcohol type may be a type of this, as these patients frequently are undernourished, though the toxic effects of tobacco and alcohol cannot be discounted. The tobacco-alcohol type frequently is found associated with an undiagnosed diabetes and the field defect is caecocentral with one or two dense nuclei. Treatment consists of abstinence from tobacco and alcohol along with massive doses of vitamins, especially the B complex.

The characteristic pathological picture of optic neuritis is perivascular lymphocytic infiltration with transudation of plasma leucocytes and red cells into the perivascular spaces. In acute cases there is arteriolar spasm that limits the passage of oxygen to the capillaries, allowing capillary anoxia and dilatation, causing them to become more permeable. This in turn leads to edema and round cell infiltration. If anoxia occurs for a sufficient length of time, necrosis and infarcts may occur. *P. Crain, Jr., M.D. Optic and Retrobulbar Neuritis. J. Louisiana M. Soc. Mar.* 1958.

CORRESPONDENCE

Clinics for crippled children listed for August

Nineteen clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count 14 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be 1 special clinic for children with cardiac conditions, 2 for children with rheumatic fever, and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August 1 — Chicago Heights (Cardiac), St. James Hospital
August 6 — Hinsdale, Hinsdale Sanitarium
August 6 — Alton (Rheumatic Fever), Memorial Hospital
August 7 — Effingham, St. Anthony Hospital
August 7 — Macomb, St. Francis Hospital
August 8 — Evanston, St. Francis Hospital
August 12 — East St. Louis, St. Mary's Hospital
August 12 — Peoria, Children's Hospital (St. Francis)
August 14 — Springfield, St. John's Hospital
August 19 — Belleville, St. Elizabeth's Hospital
August 20 — Chicago Heights (General), St. James Hospital
August 21 — Elmhurst, Memorial Hospital of DuPage Co.
August 21 — Litchfield, Madison Park School
August 21 — Rockford, St. Anthony's Hospital
August 26 — Effingham (Rheumatic Fever), St. Anthony Hospital
August 26 — Peoria, Children's Hospital (St. Francis)
August 27 — Elgin, Sherman Hospital
August 27 — Springfield (Cerebral Palsy), Memorial Hospital
August 28 — Bloomington a.m. (General), p. m. (Cerebral Palsy), St. Joseph's Hospital

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Drugs for common ailments

Drug and pharmaceutical companies might well sponsor statistical surveys to show that "big spreads" for good drugs of limited usefulness really do not pay. What might pay them dividends is the support of research for drugs useful in common ailments. Froude stated, "The knowledge which a man can use is the only real knowledge, the only knowledge which has life and growth in it and converts itself into practical power. The rest hangs like dust about the brain or dries like rain drops off the stones." *Howard R. Seidenstein. M.D. A Suburban General Practice New York J. Med. Sept.* 1, 1957.

THE P. R. PAGE

John A. Mirt

Dr. Blasingame calls for new vitality and unity in medicine

There is need for renewed vitality, professional unity, and strong leadership at all levels of organized medicine, Dr. F. J. L. Blasingame, general manager of the AMA, told the annual Public Relations Dinner of the Illinois State Medical Society in the Hotel Sherman, May 20.

"This is necessary not only to provide effective opposition to those things which we consider bad but—more important—to promote positive, constructive action on programs we believe to be good," Dr. Blasingame said.

He stressed that the main tasks of the profession should be: (1) to help assure adequate personnel, facilities, and money for medical progress—"money without the strings of statism;" (2) to stimulate fresh thinking and new approaches in medical education, training, and research; (3) to improve and co-ordinate the channels of scientific communication; and (4) to promote the fullest possible development of postgraduate education for keeping physicians abreast of the latest advances.

"Our most serious, most troublesome challenges in recent years have arisen in the socio-economic-legislative areas affecting medicine," Dr. Blasingame said. "Here the problems involve questions of how to organize and finance medical services. The essence of these problems is third party interference in the physician-patient relationship and the practice of medicine.

"The most dangerous third party threat arises from the federal government's expanding role in medical and health affairs. Some leaders in government are sincerely interested in solving problems, real or imaginary. Others are thinking primarily in terms of votes or the promotion of a particular ideology.

"Unfortunately, this mounting political occupation with medical matters has developed over a period of time when there has been a growing tendency to rely on the federal government for the solution of all problems. As a result, each session of Congress brings an increase in the number and variety of medical bills."

Dr. Blasingame traced the liberalization of the Social Security Act in recent years through expansion of the disability benefits program and establishment of a wide variety of service benefits involving medical care. He pointed out that the major challenge now is exemplified in the Forand Bill, that would provide certain hospital, nursing home, and surgical benefits to social security recipients. This would apply to an estimate 12 to 13 million people.

The AMA, he said, has had a special task force at work on all phases of this problem, and added:

"In view of many other national problems, it is a matter of conjecture whether the Forand Bill will make any headway in this session of Congress. Nevertheless, I strongly urge all of you to be alert to this issue."

Dr. Blasingame cited the need for alertness in other fields as well, since expanding federal ac-

tivity appears in many forms. All aspects of the Medicare program demand careful, constant study, because it may have an important influence on future legislation and on medicine's legislative policies.

"The medical profession also has quite a number and variety of problems involving relations with hospitals, medical schools, and medical care plans sponsored by labor unions, industries, and other lay groups," he continued.

"These are numerous and complex, revolving around arbitrary or unfair methods of judging the qualifications and competence of physicians, freedom of choice for patients, interference with the physician-patient relationship, and the ethical nature of contracts."

He pointed out that "labor is on the move and riding high, and medicine is in the path." Labor leaders are building an empire, he said, and $628 million is going into the coffers of unions yearly, more than is being spent for voluntary health insurance.

Dr. Blasingame emphasized that efforts were made to solve the economic problems of medicine within the framework of private enterprise, and he cited the growth in voluntary insurance as an example of what is being done.

"There is, however, a need for faster, more vigorous action in extending adequate coverage to old people, the rural population, and individuals not eligible for group plans," he said.

"To complete the picture, every state and locality should have an efficient, economical plan of medical care for the indigent so that particular problems cannot be used to confuse the over-all issue of medical care for the people as a whole."

Dr. Blasingame touched on other facets of the AMA program:

(1) The establishment of the American Medical Research Foundation to promote pure medical research;

(2) A study by a Board of Trustees committee looking toward improvement of the annual and clinical sessions;

(3) Stimulating experimentation in the fields of medical education, graduate training, and postgraduate education;

(4) Development of a bi-weekly AMA News which will provide quick, easy reading of organizational news and socio-economic material;

(5) Appointment of a House of Delegates—Board of Trustees commitee to concentrate on four assignments: (a) redefining the central concept of AMA objectives and basic programs; (b) placing greater emphasis on scientific activities; (c) creating more cohesion among national medical societies; and (d) studying socio-economic problems.

"The AMA must grow and change with the times," Dr. Blasingame said. "It must be a living, dynamic institution. It must be conservative, in the best sense of the word, with respect to the ethics, ideals, and traditions of medicine. But it also must be imaginative and progressive in solving the problems of medical economics.

"We are preparing the AMA from the standpoint of management to provide the profession and the public with the finest possible service. We are looking to the individual physician and his state and county medical society to develop sound policies upon which we can build our entire program. Unless you do your job, we cannot do ours.

"By promoting the fullest possible participation in the affairs of organized medicine, and by stimulating the widest possible discussion of medical issues, you can assume that the American Medical Association will become an even more vital, influential force in the life of our nation."

AT THE EDITOR'S DESK

Triacetin (glyceryl triacetate) is now available in spray and powder form as a fungicide. The product has been introduced by Ayerst Laboratories under the trade name, Enzactin. The vehicle of the spray is a propellant mixture and it is packaged in a pressurized container. The powder has a water absorbent base and is offered in "puffer" packages for dusting between the toes and in shoes and hose.

The psoralens produce a rapid tan by thickening melanin to form in the skin. The individual must be exposed to the sun for a short period to set the process into motion. 8-MOP (8-methoxypsoralen is a prescription product that promotes tanning even of "the fairest and tenderest skin." It was introduced into this country originally for the treatment of vitiligo and is manufactured by the Paul B. Elder Company of Bryan, Ohio, under the trade name, Oxsoralen. Elder has licensed Upjohn to sell a similar product known as Meloxine.

The Health Information Foundation reports that the admission rate to general hospitals has more than doubled during the past 20 years but the average length of hospitalization per patient has declined from 15 to 9.7 days. There are reasons for this change. Hospitals are being used more and more for diagnostic purposes and everyone who is seriously ill expects hospital care. A survey by the American Medical Association revealed that of the 8 million admissions a year, two-fifths are for surgery, 1 million for cardiac disease, 720,000 for fractures, and 585,000 for cancer.

Aludrox SA, is Wyeth's new antocholingeric drug that provides essential antacid and sedative action. Combined studies on 338 patients show that 84.3 per cent experienced good to excellent relief of symptoms. Of the cases, 70 per cent had peptic ulcer and the remainder a variety of gastrointestinal disturbances ranging from gastritis to spastic colon.

The Health Insurance Institute conducted a survey on 5,000 executives and found that 58.9 per cent were healthy. Only 8.1 per cent had high blood pressure and 7.6 per cent, heart disease. During the past 15 years, the number of overweight executives decreased by one-third.

The antimalarial drugs, Aralen and Plaquenil, are pushing the quinine derivatives in another field. Zeb L. Burrell, Jr. and Alberto C. Martinez found these products of value in controlling arrhythmias such as paroxymal tachycardia and ventricular extrasystoles. A favorable response to Aralen was obtained in 18 of 31 patients with auricular fibrillation. According to the report of these physicians in the New England Journal of Medicine, the initial dose was

one gm. daily in divided doses, which was increased by 0.25 gm. every third day.

New chemical and therapeutic studies on psoriasis were reported at a New York Academy of Medicine conference. Peter Flesch was able to isolate five distinctive chemical abnormalities in the scales of psoriatic lesions. He found that allantoin dissolved the scales. Sidney G. Clyman and Jacob Bleiberg then reported on the beneficial effects of a combination of allantoin and a tar compound in a lotion base (Alphosyl). The majority of cases cleared completely or improved greatly. Confirmation of this work is needed.

Toa (triacetyloleandomycin) is Roerig's latest medium spectrum antibiotic. It contains glucosamine. Comparative studies show that blood levels average two to six times higher and urinary concentration about 300 per cent greater than obtained with erythromycin.

Pfizer reports, in a news release that its Cosa-Tetracyn cured 45 of 50 women with acute or chronic gynecologic infections.

Bristol's new Japanese antibiotic, Kanamycin, is being marketed under the name Kantrex. The antibiotic is said to be effective against strains of resistant staphylococci.

Parke, Davis will manufacture the APC vaccine against respiratory infections for use by the armed services next year.

Lilly suspended production of polio vaccine June 1. Its inventory was too large in relation to public apathy toward immunization. One year ago the company had 275 employees working on the vaccine; 215 of these men and women are being shifted to other assignments. Parke Davis, Pitman-Moore, and Merck, Sharp & Dohme also have discontinued production of this vaccine.

Deaner, a new prescription product of Riker Laboratories, was discussed at the annual meeting of the Society of Biological Psychiatry. This antidepressant drug is supposed to increase drive and physical energy. According to the report, Deaner increased muscle tone of medical students as well as their power of mental concentration; it also changed their "sleep habits in that less sleep was needed and they awakened more alert in the morning." Deaner is believed to be a precursor of acetylcholine.

Nicozol (pentylenetetrazol and niacin) with reserpine was used in a series of 75 cases of senile psychoses with improvement in 65 (87 per cent). No convulsions occurred during treatment and relief of agitation and restlessness was noted together with improved memory, behavior, sociability, appearance, and tidiness.

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NEWS of the STATE

COOK

EUROPEAN TALK. Dr. Edmund Jacobson, director of the Laboratory for Clinical Physiology, Chicago, spoke on "Scientific Versus Unscientific Methods of Relaxation" at a meeting of the Societe Francaise de Medecine Psychosomatique in Paris, May 5. Dr. Jacobson spoke in behalf of the Foundation for Scientific Relaxation, Inc. of which he is a director.

HOSPITALS. One hundred civic and medical leaders participated in ceremonies on May 26 dedicating expanded facilities of the Rehabilitation Institute of Chicago. The occasion marked the formal opening of the institute's new in-patient hospital accommodations and completion of its $1,500,000 modernization program. Latest rehabilitation and physical therapy equipment includes a $50,000 hydrotherapy department, the gift of the Robert R. McCormick Charitable Trust. Dr. Joseph Chivers is director of the nonprofit organization which seeks to rehabilitate its patients physically, socially, and vocationally.

Dr. Clifford J. Barborka was installed as Passavant Memorial Hospital medical staff president on June 2. He succeeds Dr. John I. Brewer.

The new medical staff officers at Mercy Hospital are Drs. Joseph E. Laibe, chief of staff; Cornelius Annan, vice-president; and William F. Cernock, secretary-treasurer. Drs. Arkell M. Vaughn and Harold C. Voris were nominated to serve on the Executive Board of the hospital.

1958-59 OFFICERS. Chicago Neurological Society elected the following new officers: Drs. John J. Madden, president; Milton Tinsley, vice-president; and Meyer Brown, secretary.

Chicago Society of Industrial Medicine and Surgery named Drs. Walter J. Phillips, president; George L. Cooper, vice-president; Bille Hennan, secretary; and Charles Drueck, treasurer.

Chicago Ophthalmological Society elected Drs. J. Vernal Cassady, president; Clifford Sullivan, president-elect; Manuel L. Stillerman, vice-president; Joseph S. Haas, secretary-treasurer; Theodore N. Zekman, councilor; and David Shoch, recording secretary.

Chicago Urological Society elected Drs. George O. Baumrucker, president; Cornelius W. Vermeulen, vice-president; and David Presman, secretary-treasurer.

Illinois Psychiatric Society elected Drs. Nathaniel S. Apter, president; Frances Hannett, president-elect; and Paul Nielson, secretary-treasurer.

DEKALB

MEDICAL CENTER. The physicians of the DeKalb Medical Center are occupying their new single story, fireproof building on North First Street Road. The building is airconditioned the year around, and contains 90 rooms. It provides office space for six physicians and surgeons, an eye and ear specialist, and three dentists. There

is a modern clinical laboratory, an X-ray department, and a physical therapy department. The structure is planned to aid the physicians and dentists in giving better care of office patients now, and for later expansion should the needs of the community require it.

FULTON

TALK. At the Fulton County Medical Society June meeting, Dr. Ralph Davis, Quincy, spoke on "Isotopes."

LA SALLE

TOUR. The LaSalle County Medical Society—in place of its usual monthly meeting—made a visit to the Argonne National Laboratories at Lemont, June 12. The afternoon was devoted to a tour of the laboratories, and the scientific meeting followed dinner. Office help, technicians, nurses, and wives of physicians were given a special program.

McDONOUGH

HONORED. Recently Dr. W. E. Carnahan, a physician in Macomb since 1914, was named the city's outstanding citizen by the Chamber of Commerce. At the banquet in his honor, Dr. Carnahan was presented with a document containing the names of 3,097 babies he had delivered during his years of practice in Macomb.

GENERAL

BERTHA GOLDBLATT TEPLITZ AWARD. Drs. Charles Heidelberger and David Pressman have been jointly named the first recipients of a new annual award for meritorious investigation by a scientist under 45 in the field of cancer, awarded by the Ann Langer Cancer Research Foundation of Chicago. The men will share the $500 honorarium. Dr. Charles Heidelberger received the award for his "Basic Research on 5-Fluoro-Uracil," and Dr. Pressman for "Developing Technique for Labeling Antibodies with Radioactive Isotopes."

HONORARY DEGREES. Three distinguished scientists were awarded honorary degrees by the University of Chicago at the afternoon session of its 278th Convocation in Rockefeller Memorial Chapel on June 13.

The honorary degree of Doctor of Science (D.Sc.) was conferred upon Dr. George W. Corner, member of the Rockefeller Institute for Medical Research; Dr. Nicholson J. Eastman, professor and chairman of the department of obstetrics and gynecology, Johns Hopkins Medical School; and Dr. Richard E. Shope, member of the Rockefeller Institute for Medical Research.

Considered a leading scholar in the field of mammalian reproduction, Dr. Corner has done much research in embryology which led to detailed studies in the physiology of reproduction. He is best known for his isolation and purification of the pregnancy hormone, progesterone, work done in collaboration with Dr. Willard Allen.

Dr. Eastman, a teacher as well as researcher, has concentrated his work on studies of the human fetus and of the toxemias of pregnancy. In recent years his interests have included the public health aspects of maternal welfare and child health. He has served as chairman of the committee on maternal and child health services of the Children's Bureau and of the expert committee on maternity care of the World Health Organization.

A researcher who has spent his entire career studying animal diseases, Dr. Shope has made important contributions to the fundamental knowledge of virus infections and to the study of cancer. Among his discoveries are the virus of swine influenza and its complicated route of transmission, and two rabbit tumors produced by viruses which are important experimental tools in the study of cancer. He also developed an effective vaccine against rinderpest, a highly contagious disease of cattle.

LECTURES ARRANGED BY THE ILLINOIS STATE MEDICAL SOCIETY

RALPH N. REDMOND, Sterling, senior staff member of the Sterling Community General Hospital, addressed the Bureau County Medical Society in Princeton, June 10, on "The Problem of Sterility."

MARK C. WHEELOCK, associate professor of pathology, Northwestern University Medical School, addressed a joint meeting of the Whiteside and Lee County Medical Societies in Sterling, June 19, on "Extranodal Lymphomas."

JOHN J. BROSNAN, assistant clinical professor in surgery, Stritch School of Medicine of Loyola University, addressed the Stephenson County

Medical Society in Freeport, June 19, on "Diagnosis of Lung Tumors."

RALPH N. REDMOND, Sterling, senior staff member of the Sterling Community General Hospital, addressed the White Eagle Homemakers' Camp in Leaf River, July 1, on "Antibiotics."

CHARLES I. FISHER, associate in medicine, Northwestern University Medical School, addressed the Kiwanis Club of Edgebrook, July 16, on "Physical and Mental Hazards of Aging."

DEATHS

LEON BLOCH, retired, formerly of Chicago, who graduated at Rush Medical College in 1903, died May 14, aged 79. He was a former chairman of the department of medicine at Michael Reese Hospital, and professor of medicine at Rush Medical College.

GERALD M. CLINE*, retired, Bloomington, who graduated at the University of Illinois College of Medicine in 1920, died May 17, in Fort Lauderdale, Fla., aged 61. He had served as consultant in pediatrics for the Illinois Department of Public Welfare.

ELMO E. DILLON*, Homewood who graduated at Northwestern University Medical School in 1927, died May 13, aged 59. He was a member of the staffs of Ingalls Memorial Hospital, Harvey, and St. James Hospital, Chicago Heights, and was an attending physician at the Oak Forest Infirmary.

WALTER A. DZIUK*, Chicago, who graduated at the Chicago Medical School in 1930, died May 21, aged 60. He was a former professor of pathology at the Chicago Medical School and a past president of the Northwest Branch of the Chicago Medical Society.

JOSEPH GALE, retired, Miami Beach, Fla., formerly of Chicago, who graduated at the University of Illinois College of Medicine in 1923, died May 14, aged 62.

NEIL C. GEIS*, retired, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1913, died June 3, aged 70. He was a member of the staff of the Ravenswood Hospital for many years.

MOSE S. GRIFFITH*, Galesburg, who graduated at Miami Medical College, Cincinnati, in 1909, died May 4, aged 75.

DAVID L. HARNETT*, Chicago Heights, who graduated at Northwestern University Medical School in 1926, died May 27, aged 63. He was a member of the staff of St. James Hospital, Chicago Heights.

AIME PAUL HEINECK, Chicago, who graduated at Northwestern University Medical School in 1896, died April 8, aged 88, of cancer of the bladder and arteriosclerosis. At one time he served on the faculty of his alma mater, and on the staffs of the Walther Memorial, Passavant Memorial, and Jackson Park Hospitals.

CLARENCE LOWELL HOBBS, Collinsville, who graduated at St. Louis College of Physicians and Surgeons in 1922 and the Kansas City (Mo.) College of Medicine and Surgery in 1922, died March 23, aged 73, of arteriosclerotic heart disease and cancer of the prostate.

ANTON KNUTSON*, Reynolds, who graduated at the Chicago College of Medicine and Surgery in 1914, drowned May 25 in Parent Lake, in northern Minnesota. He was 73. Internationally known as a big game hunter, he was a member of the Illinois State Historical Society, the International Explorers Club of New York, the Polar Bear Club of London, and the Adventurers Club of Chicago.

ANDREW J. LYONS, a retired Army medical corps major, Highland Park, who graduated at the Chicago College of Medicine and Surgery in 1916, died in Great Lakes Naval Hospital, May 12, aged 83. For 20 years he had been a resident physician at Hines Veterans Administration Hospital.

WILLIAM THOMAS MOFFETT, retired, Blue Mound, who graduated at Rush Medical College in 1895, died February 20, aged 90, of acute cardiac failure.

JOHN P. RINGA*, Chicago, who graduated at the Chicago Medical School in 1934, died May 15, aged 55. He was a member of the staffs of Martha Washington and Walther Memorial Hospitals.

LEWIS H. RUTTENBERG, retired, Lincolnwood, who graduated at Milwaukee Medical College in 1912, died May 11, aged 74. He was formerly assistant chief surgeon of the Chicago Rapid Transit Co. and later served as medical examiner of the Chicago Transit Authority.

GEORGE F. SCHROEDER*, Itasca, who grad-

*Indicates member of the Illinois State Medical Society.

uated from Northwestern University as a pharmacist in 1898 and as a doctor of medicine in 1905, died May 18, aged 80. He was a former village president and trustee of Itasca and was one of the founders of the DuPage Memorial Hospital in Elmhurst. He had practiced medicine in Itasca over half a century.

ROBERT E. SMITH*, Springfield, who graduated at Northwestern University Medical School in 1914, died May 7, aged 68. He had served with the Otis Medical Unit overseas during World War I.

JONATHAN E. WAGGONER, retired, Downers Grove, who graduated at Northwestern University Medical School in 1904, died May 8, aged 83. He was a member of the staff of Swedish Covenant Hospital for 37 years.

ANTHONY OBEDIAH YOUNG, retired, Butler, who graduated at Beaumont Hospital Medical College, St. Louis, in 1893, died February 22, aged 89.

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Adverse allergic reactions

The Medihaler with epinephrine is on my treatment table at all times, and it has been used at the first sign of any adverse allergic reaction to an injectable drug. It will stop these reactions readily, and it is more acceptable to the average patient than an injection of adrenalin. It has been used by several of my patients during intravenous pyelograms with complete relief of many of the adverse symptoms which in previous injections had caused considerable distress. It has also been found effective in cases of acute and chronic angioneurotic edema in which there is swelling of the epiglottis or larynx. One of my patients who has had severe anaphylactoid reactions to the sting of a bee, and who had refused desensitization, has been carrying one of these Medihalers with him at all times and has been stung twice thus far without systemic reactions upon using the aerosol immediately after any insect sting. I feel that this device is a simple, effective, and inexpensive way to get epinephrine into the system and should be a part of the doctor's anaphylactic kit. *Alvin Seltzer, M.D. A Useful Device for Treating Acute Allergic Drug Reactions—The Medihaler—Epi. M. Ann. District of Columbia, March* 1958.

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Liver tests versus biopsy

Blind needle biopsy of the liver has become established since Roholm and Iversen reported the first large series in 1939. It has been used not only for the differential diagnosis of hepatic disease but also to study prognosis and response to treatment and in attempts to correlate structure and function. Waldenstein *et al.* found quite a close association between liver cell damage and positive serum flocculation tests, and between scarring and ascites with a low serum albumin. They concluded that the microscopic appearances of the liver were not an accurate guide to prognosis. It has been suggested that the main value of blind liver biopsy is in distinguishing between "medical" and "surgical" jaundice. In about 15 per cent of cases this differential diagnosis can be difficult; but even biopsy does not always solve the problem. *Editorial. Hepatic Cytology. Lancet Dec.* 28, 1957.